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SALUS POPULI SUPREMA LEX ESTO

“The welfare of the people shall be the supreme law.”



JASON KANDER
SECRETARY OF STATE

MISSOURI
REGISTER

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SECRETARY OF STATE

JASON KANDER

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

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•

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•

ADMINISTRATIVE ASSISTANT

ALISHA DUDENHOEFFER

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April 1, 2016	May 2, 2016	May 31, 2016	June 30, 2016
April 15, 2016	May 16, 2016	May 31, 2016	June 30, 2016

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

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HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 12—Forensic Examinations**

EMERGENCY RULE

11 CSR 30-12.020 Payments for Child Physical Abuse Forensic Examinations

PURPOSE: This rule sets out the requirements of submitting a claim for payment, establishes the criteria by which expenses are paid, and sets out the maximum payment for SAFE-CARE providers who perform or provide a case review of a forensic examination of a person under eighteen (18) years of age who is an alleged victim of physical abuse.

EMERGENCY STATEMENT: The Department of Public Safety finds that this emergency rule is necessary to preserve a compelling governmental interest in establishing eligibility criteria as well as maximum reimbursement rates by which the department will pay for a child physical abuse forensic examination or case review of a child physical abuse forensic examination to ensure sufficient availability of funds for those purposes.

On August 28, 2014, section 334.950.5, RSMo went into effect, which specifically authorized the department to establish rules and make payments to SAFE-CARE providers who perform a child physical abuse forensic examination or a case review of a child physical abuse forensic examination. In addition, language was added to sec-

tion 334.950, RSMo that instructed the department to establish maximum reimbursement rates for charges which reflect the reasonable cost of providing the child physical abuse forensic examination as well as establish criteria for payment eligibility. On July 1, 2015, appropriations were allocated, for the first time, for these payments. Subject to this appropriation, an emergency rule is necessary to ensure the efficient use of the appropriated funds in order to reimburse SAFE-CARE providers for as many child physical abuse forensic examinations and case reviews as possible. If the emergency rule is not enacted, the necessary criteria will not be in place to ensure that funds are available to reimburse appropriate expenses.

Over the course of several months, the department held a series of meetings with stakeholders in order to share draft rule language and accept feedback. The rule language has been revised multiple times to address specific concerns raised during these meetings.

This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the Missouri and United States Constitutions. The department believes this emergency rule is fair to all interested persons and parties. This emergency rule was filed November 2, 2015, becomes effective November 12, 2015, and expires on May 9, 2016.

(1) For purposes of this section, the following terms mean:

(A) “Child abuse medical resource centers” - medical institutions affiliated with accredited children’s hospitals or recognized institutions of higher education with accredited medical school programs that provide training, support, mentoring, and peer review to SAFE-CARE providers in Missouri;

(B) “SAFE-CARE provider” - a physician, advanced practice nurse, or physician’s assistant licensed in this state who provides medical diagnosis and treatment to children suspected of being victims of abuse and who receives—

1. Missouri-based initial intensive training regarding child maltreatment from the SAFE-CARE network;

2. Ongoing update training on child maltreatment from the SAFE-CARE network; and

3. Peer review and new provider mentoring regarding the forensic evaluation of children suspected of being victims of abuse from the SAFE-CARE network;

(C) “Sexual assault forensic examination child abuse resource education network” or “SAFE-CARE network” - a network of SAFE-CARE providers and child abuse medical resource centers that collaborate to provide forensic evaluations, medical training, support, mentoring, and peer review for SAFE-CARE providers for the medical evaluation of child abuse victims in this state to improve outcomes for children who are victims of or at risk for child maltreatment by enhancing the skills and role of the medical provider in a multidisciplinary context;

(D) “Child physical abuse forensic examination” - a physical examination performed on an alleged victim of physical abuse who is under eighteen (18) years of age by a SAFE-CARE provider to collect and preserve evidence;

(E) “Case Review” - a written record review or evaluation of previously gathered photographs, medical records, including, but not limited to, radiology and laboratory tests, medical chart documentation, and investigative information including, but not limited to, information provided by a multi-disciplinary team, Missouri Children’s Division, law enforcement, or juvenile authorities; and

(F) “Department” - the Missouri Department of Public Safety.

(2) All claims for reimbursement of a child physical abuse forensic examination shall be submitted to the department’s Child Physical Abuse Forensic Examination Program as a payor of first resort within ninety (90) days of the child physical abuse forensic examination. All claims for reimbursement of case reviews shall be submitted within one hundred eighty (180) days after the child physical abuse forensic

examination. The department shall only reimburse professional fees to SAFE-CARE providers who perform a child physical abuse forensic examination or professional fees to SAFE-CARE providers who provide a case review of a child physical abuse forensic examination. The department shall not reimburse providers for medical procedures, facility fees, supplies, laboratory/radiology tests, court preparation, or court testimony.

(3) All claims for reimbursement shall be made on the Child Physical Abuse Forensic Examination form. The SAFE-CARE provider must ensure that all fields of the claim form are completely and legibly filled out. If the claim form is incomplete or unsigned, the claim may be rejected or denied.

(4) The Child Physical Abuse Forensic Examination form must include all applicable signatures, including consent or authorization for the child physical abuse forensic examination as well as the signature of the SAFE-CARE provider who performed the child physical abuse forensic examination and/or the signature of the SAFE-CARE provider who performed the case review, if applicable.

(5) All claims for reimbursement shall include an itemized billing invoice which includes appropriate charge amounts for the child physical abuse forensic examination or case review including the accompanying current International Classification of Disease (ICD) code(s). Written explanation and reasoning may be required to justify certain codes.

(6) The itemized billing statement must include at least one (1) of the following ICD diagnosis codes as applicable:

(A) With forensic findings—

1. Child abuse, unspecified - 995.50
2. Child physical abuse - 995.54
3. Shaken infant syndrome - 995.55
4. Other child abuse and neglect - 995.59; or

(B) With no forensic findings—

1. Observation following other inflicted injury - V71.6
2. Abuse and neglect - V71.81.

(7) Maximum reimbursement for eligible claims shall be—

(A) Seven hundred fifty dollars (\$750.00) for a child physical abuse forensic examination; or

(B) Four hundred dollars (\$400.00) for a case review of the child physical abuse forensic examination.

(8) Professional fee charges for the child physical abuse forensic examination or case review shall not be billed to other payment resources, such as the patient's parent or guardian, health insurance, Medicaid, or Medicare.

(9) If the same SAFE-CARE provider performs both the child physical abuse forensic examination and the case review on the same child, such provider cannot be reimbursed for both, but may be reimbursed for one (1) if all criteria are met.

(10) Only one (1) child physical abuse forensic examination per report of physical abuse on an alleged victim may be reimbursed and no reimbursement will be made for any subsequent exam on the same victim. Reimbursement will not be made for more than one (1) case review per report of physical abuse and no reimbursement will be made for any subsequent case review for the same victim.

(11) In the event that the child has been the victim of both physical and sexual abuse, the department will reimburse one (1) forensic examination performed per report of abuse, whether sexual, physical, or both. A claim for reimbursement may be submitted to only one (1) program, either the Child Physical Abuse Forensic Examination

Program or the Sexual Assault Forensic Examination (SAFE) Program.

(12) For a claim to be eligible for reimbursement by the Child Physical Abuse Forensic Examination Program—

(A) The alleged physical abuse incident must have occurred in Missouri; or

(B) The alleged victim of physical abuse must be a Missouri resident.

(13) The department, at its discretion, may require additional information regarding the child physical abuse forensic examination or case review for auditing purposes.

AUTHORITY: section 334.950, RSMo Supp. 2014. Emergency rule filed Nov. 2, 2015, effective Nov. 12, 2015, expires May 9, 2016. A proposed rule covering this same material is published in this issue of the Missouri Register.

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 41—General Tax Provisions

EMERGENCY AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The department proposes to amend section (1).

PURPOSE: This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2016.

EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2016 calendar year. A proposed amendment, that covers the same material, is published in this issue of the Missouri Register. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with protections extended by the Missouri and United States Constitutions. Emergency amendment filed October 22, 2015, effective January 1, 2016, expires June 28, 2016.

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year, has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%

2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%

AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 22, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (33), (54), (60), (61), and (62), adding section (35), and renumbering as necessary.

PURPOSE: This amendment revises definitions for experimental/investigational/unproven, primary care physician, prior authorization, and provider; revises a section reference in the definition of participant; and adds a definition for foster parent.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the

Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(33) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

[(B)] Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

[(C)](B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis; or

[(D)](C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(35) Foster parent. Any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.

[(35)](36) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

[(36)](37) Health assessment (HA). An online questionnaire about a member's health and lifestyle habits required for participation in the Strive for Wellness® Partnership Incentive.

[(37)](38) Health Savings Account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

[(38)](39) Health Savings Account (HSA) Plan. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(39)](40) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

[(40)](41) Incident. A definite and separate occurrence of a condition.

[(41)](42) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

[(42)](43) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

[(43)](44) Long-term disability subscriber. A subscriber eligible for long-term disability coverage from Missouri State Employees' Retirement System (MOSERS), Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), or another retirement system whose members are grandfathered for coverage under the plan by law.

[(44)](45) MCHCPid. An individual MCHCP subscriber identifier used for member verification and validation.

[(45)](46) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, retrieve and send secure messages, upload documents, and access health plan websites.

[(46)](47) Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are—

(A) Expected to be of clear clinical benefit to the member;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;

(C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

[(47)](48) Medicare-allowed amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

[(48)](49) Medicare Prescription Drug Plan (PDP). The Medicare Prescription Drug Plan, administered by Express Scripts Medicare PDP, is a Medicare Part D Plan with additional coverage to ensure Medicare members have similar benefits to non-Medicare members.

[(49)](50) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(50)](51) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

[(51)](52) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

[(52)](53) Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

[(53)](54) Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

[(54)](55) Participant. Shall have the same meaning as the term member defined herein (see member, section **[(49)](50)**).

[(55)](56) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

[(56)](57) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

[(57)](58) Plan year. The period of January 1 through December 31.

[(58)](59) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

[(59)](60) Premium. The monthly amount that must be paid for health insurance.

[(60)](61) Primary care *[physician]* provider (PCP). An internist, family/general practitioner, *[or]* pediatrician, or **physician assistant or nurse practitioner in any of the practice areas listed in this definition.**

[(61)](62) *[Prior authorization]* **Prior authorization.** A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called *[preauthorization]* **prior authorization**, prior approval, or precertification. The plan may require *[prior authorization]* **preauthorization** for certain services before the member receives them, except in an emergency. *[Prior authorization]* **Prior authorization** is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request *[prior authorization]* **preauthorization.**

[(62)](63) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(22). Other providers include, but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker (LCSW);

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

[(63)](64) Prudent layperson. An individual possessing an average knowledge of health and medicine.

[(64)](65) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a

dependent child or member if the plan normally provides coverage for dependent children.

[(65)](66) Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a “retiree” is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

[(66)](67) Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

[(67)](68) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

[(68)](69) Specialty medications. High-cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

[(69)](70) State. Missouri.

[(70)](71) Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

[(71)](72) Subrogation. The substitution of one (1) “party” for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

[(72)](73) Subscriber. The person who elects coverage under the plan.

[(73)](74) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

[(74)](75) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

[(75)](76) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(76)](77) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

[(77)](78) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

[(78)](79) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(79)](80) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(80)](81) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership
EMERGENCY AMENDMENT**

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth, employee and dependent effective dates when adding coverage due to a life event, deadline for proof of eligibility documentation, documentation requirements for disabled dependents, premium payment deadlines for Medicare primary members, documentation required to terminate coverage due to the death of a dependent, and removes repetitive language regarding addition of dependents.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

B. Active Employee Coverage of a Spouse.

(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.

C. Retiree Coverage of a Spouse.

(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP.

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's date of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for

the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee/eligible variable-hour employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES or another designated enrollment system. Except at initial employment or when identified as an eligible variable-hour employee, an employee and his/her dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for **[newborns] coverage being added due to a birth, adoption, or placement of children**, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP. In no case, shall an eligible variable-hour employee and his/her dependents' coverage begin before January 1, 2015.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

B. Newborn.

(I) If a subscriber or employee enrolls **[his/her] an eligible newborn [or a subscriber enrolls a newborn of his/her dependent]** within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.

[[/]](III) If a subscriber does not elect to enroll a newborn of a dependent **child** within thirty-one (31) days of birth, s/he cannot enroll the newborn of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption[;].

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the

date of adoption, or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Employee.

(I) If an employee enrolls due to a life event or loss of employer-sponsored coverage, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before the participation in MCHCP coverage terminates, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event **or loss of employer-sponsored coverage.**

5. An employee who terminates all employment with the state and is rehired in the following month and his/her eligible dependent(s) who were covered by the plan may choose to have continuous coverage or coverage the first of the month after his/her hire date if an enrollment form is submitted within thirty-one (31) days of hire date.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

6. An employee who transfers in the same month from a state agency with MCHCP benefits to another agency with MCHCP benefits, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage. The employee must inform the former agency of the transfer in lieu of a termination. The employee will be transferred through eMCHCP by the former state agency's human resource or payroll representative to the new state agency.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

sored coverage.

7. For continuous coverage, an active employee who terminates employment with the state may transfer coverage of him/herself and his/her dependents, **if eligible**, to his/her spouse **or parent** who is an MCHCP subscriber if the spouse **or parent** completes an Enroll/Change/Cancel form within thirty-one (31) days of coverage termination of the active employee's employment.

8. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

A. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

9. A state employee who has medical coverage under MCHCP and transfers state employment to MoDOT, Missouri State Highway Patrol, or the Department of Conservation and his/her dependents are no longer eligible for MCHCP coverage. MCHCP medical coverage is terminated the last day of the month of the employee's termination.

10. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the */letter/* date **MCHCP processed the enrollment**, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. **If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.**

(A) *[Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the spouse/child(ren) not having coverage until such proof is received, subject to the following:*

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility;

2./ When enrolling a newborn, the member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form

and letter notifying the member of the steps to initiate coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; and

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years **and** may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; **and**, Evidence could be from the Social Security Administration, representation from the dependent's or child's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and

C./B. A benefit verification letter dated within the last twelve (12) months from the [Social Security Administration (SSA)] confirming the child is still considered disabled [by SSA].

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage.

A. Non-Medicare primary subscribers—If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber and his/her dependents will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period[.].

B. Medicare primary subscribers—If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to active employee(s) and his/her dependents, the employer has determined that the active employee is no longer an eligible variable-hour employee;

5. With respect to dependents, upon divorce or legal separation from the subscriber or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her enrolled

ex-spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

6. Death of dependent. The dependent's coverage ends on the date of death[. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death];

7. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

8. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP; or

9. A member otherwise loses benefit eligibility.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the term "prior authorization" to "preauthorization" and clarifies the requirements for preauthorization of physical, speech, and occupational therapy and rehabilitation services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the

Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) *[Prior Authorization of Services] Preauthorization*—The claims administrator must authorize some services in advance. Without *[prior authorization] preauthorization*, any claim that requires *[prior authorization] preauthorization* will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to *[prior authorization] preauthorization* under this rule. *[Prior authorization] Preauthorization* does not verify eligibility or payment. *[Prior authorizations] Preauthorizations* found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to *[prior authorization] preauthorization*:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care;

K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

L. Genetic testing or counseling;

M. Hearing Aids;

N. Home health care;

O. Hospice care and palliative services;

P. Hospital inpatient services;

Q. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

R. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

S. Nutritional counseling after six (6) sessions annually;

T. Orthognathic surgery;

U. Orthotics over one thousand dollars (\$1,000);

V. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per *[incident] calendar year*;

W. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

X. Prostheses over one thousand dollars (\$1,000);

Y. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Z. Skilled nursing facility;

AA. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep

apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

BB. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to *[prior authorization] preauthorization*:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; **and**

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy; **and**].

3. *[Prior authorization] Preauthorization* timeframes.

A. A benefit determination for non-urgent *[prior authorization] preauthorization* requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent *[prior authorization] preauthorization* requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision; **[and]**

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review./.;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment./.; **and**

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RESCISSION

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 300 Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. A proposed rescission covering this same material is published in the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RULE

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for

members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, three hundred dollars (\$300); family, six hundred dollars (\$600) and for non-network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family three thousand dollars (\$3,000) and for non-network: per individual, three

thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling; and

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit.

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(11) Usual, customary, and reasonable fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RESCISSION

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in

regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 600 Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. A proposed rescission covering this same material is published in the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RULE

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premi-

ums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200) and for non-network: per individual, one thousand two hundred dollars (\$1,200); family, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000) and for non-network: per individual, three thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to all payment information of the family unit.

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans during the plan year or continues enrollment under another subscriber's plan within the same plan year.

(10) Copayments—Copayments apply to network services unless otherwise specified.

(A) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emer-

gency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(11) Usual, customary, and reasonable limit fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify the Health Savings Account Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for

reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission covering this same material is published in the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE**

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emer-

gency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, four thousand dollars (\$4,000); family, eight thousand dollars (\$8,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—three thousand three hundred dollars (\$3,300);

2. Network out-of-pocket maximum for family—six thousand six hundred dollars (\$6,600);

3. Non-network out-of-pocket maximum for individual—five thousand dollars (\$5,000); and

4. Non-network out-of-pocket maximum for family—ten thousand dollars (\$10,000).

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutritional counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Newborn's claims will be subject to deductible and coinsurance.

(9) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(10) Each subscriber will have access to payment information of the family unit.

(11) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(12) Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(13) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(15) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(16) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (19) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

(17) If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.

(18) If a subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber must enroll in a non-HSA Plan within thirty-one (31) days of notice from MCHCP. If no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan.

(19) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(20) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on

the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar (\$300) contribution to each spouse to total maximum six hundred dollars (\$600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	\$300.00	\$600.00
April (delayed contribution due to health care FSA grace period)	\$300.00	\$600.00
All others	A proration of \$300	A proration of \$600

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the *Code of State Regulations*. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3); and renumbering as necessary.

PURPOSE: This amendment clarifies the following benefits: allergy testing and immunotherapy, bariatric surgery, contraception and sterilization, durable medical equipment, foot care, genetic counseling, genetic testing, hospice, hospital, preventive services, transplants, and urgent care; corrects the alphabetical order of benefits by moving Bone Growth Stimulators to paragraph (3)(E)4.; and adds coverage of blood pressure cuffs/monitors with a diagnosis of diabetes.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(3) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HSA Plan.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. *[No coverage for no provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]* Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants)

hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, [*Ana-Kit*, and *Epi-Pen kits*] to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by **the** *[one (1) of the following accreditation programs:*

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[5./6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity[.]; [The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;]

[6./7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

[7./8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

[8./9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

[9./10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification

of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

/10./11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

/11./12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now

bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

[12.]/13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

[13.]/14. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider.

[14.]/15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

[F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;]

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[15.]/16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

[16.]/17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

[17.]/18. Foot care (trimming of nails, corns, or calluses). *[Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe*

circulatory insufficiency or areas of desensitization in the lower extremities.] Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[18.]/19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals *[from ethnic groups]* recognized to be at increased risk for *[specific]* genetic disorders *[(e.g., African Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease)]*;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with *[mental retardation]* **intellectual developmental disorders**, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[19.]/20. Genetic testing. *[No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA).]*

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

[A.]/(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

/B./(II) The result of the test will directly impact the treatment being delivered to the member;

/C./(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

/D./(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

*/20./*21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*/21./*22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

*/22./*23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

*/23./*24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*/24./*25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

*/25./*26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accruited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within *[six (6) months/ twelve (12) months]* of death;

*/26./*27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services *[not otherwise offered in an outpatient setting]* **provided on less than a full-time basis.** *[The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week.]* The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; **and**

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; *and/*

[(VI) Inpatient treatment in a network hospital or facility by a non-network provider. Inpatient treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;]

[27.]28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Idiopathic progressive polyneuropathy;

[28.]29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[29.]30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home.

[30.]31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[31.]32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[32.]33. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service,

procedure, or related treatment plan;

/33./34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

/34./35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;
B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

/35./36. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated

AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;
- (c) Calcaneal bursitis (acute or chronic);
- (d) Calcaneal spurs (heel spurs);
- (e) Conditions related to diabetes;
- (f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);
- (g) Medial osteoarthritis of the knee;
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;
- (d) Structural deformities such as tarsal coalitions; or
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or
- (IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

- (a) Previous amputation of the other foot or part of either foot;
- (b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[36./37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. *[Annual physical]* Preventive exams and routine lab and X-ray services ordered as part of the *[annual]* exam. *[One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.]* For benefits to be covered as preventive, including X-rays and lab services, they must be coded by *[your physician]* the provider as routine, without indication of an injury or illness.

F. Cancer screenings. **One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—**

(I) Mammograms—*[one (1) exam per year,]* no age limit;

(II) Pap smears—*[one (1) per year,]* no age limit;

(III) Prostate—[one (1) per year,] no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema [per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.]

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

[37.]38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[38.]39. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[39.]40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[40. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.]

41. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19)

years travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parents(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered[.]; *[Non-network facility charges and payments for transplants are limited to the following maximums:*

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);]

44. Urgent care. *[Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care]* Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: *This amendment adds limitations for the following medical benefits, services, or supplies: genetic counseling, non-provider allergy services, or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning, non-covered drugs, non-reusable disposable supplies, and routine foot care without the presence of systemic disease that affects lower extremities. These items were previously contained in 22 CSR 10-2.055. In addition, this amendment clarifies limitations regarding experimental/investigational/unproven services, procedures, supplies, or drugs; athletic services; physical fitness; and therapy for improvement of athletic performance. Non-medically necessary services was moved to subsection (1)(NN) and services obtained at a government facility if care is provided without charge was moved to subsection (1)(WW) to correct the alphabetical order of the subsections in section (1).*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055.

(F) Athletic *[training]* enhancement services and sports performance training.

(V) *[Experimental or investigational]* Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

[(X)] Services obtained at a government facility if care is provided without charge.]

[(Y)](X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

(Y) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(MM) Drugs that the pharmacy benefit manager (PBM) has

excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advanced by the PBM.

(NN) Non-medically necessary services.

(OO) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(PP) Non-reusable disposable supplies.

/(MM)/(QQ) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

/(NN)/(RR) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

/(OO)/(SS) Physical and recreational fitness.

/(PP)/(TT) Private-duty nursing.

(UU) Routine foot care without the presence of systemic disease that affects lower extremities.

/(QQ)/(VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.

/(RR) Services not medically necessary.]

(WW) Services obtained at a government facility if care is provided without charge.

/(SS)/(XX) Sex therapy.

/(TT)/(YY) Surrogacy—pregnancy coverage is limited to plan member.

/(UU)/(ZZ) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

/(VV)/(AAA) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance [or for recreation];

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; **and**

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

/(WW)/(BBB) Travel expenses.

/(XX)/(CCC) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the order of benefit determination rules.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help

protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan's [has] rules [coordinating its benefits with those of MCHCP; and

2. Both those rules] and MCHCP's rules require MCHCP [benefits be determined before those of the other plan] to be primary; or

2. The other plan's rules conflict with MCHCP's rules, then the plan that has been in effect the longest is primary.

AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2014] 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

PURPOSE: This amendment clarifies appeals must be made within one hundred eighty (180) days of issuance of the denial or notice, changes the name Coventry Health Care of Kansas, Inc. to Aetna, updates Aetna appeal address, fax, and telephone contact information, updates the address for Pharmacy Lock-In Program appeals, and removes language regarding appeals of a late submission of a Health Care Provider Form.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits

and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(2) General Appeal Provisions for Medical and Non-Medicare Primary Pharmacy Services.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of [receiving] issuance of the denial or notice which gave rise to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR, [Coventry Health Care of Kansas, Inc.] Aetna, and Express Scripts, Inc. that involve medical judgment (including,

but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-/3/2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by

someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Coventry Health Care of Kansas, Inc.] Aetna—*

(a) First and second level appeals must be submitted in writing to—

*[Coventry Health Care of Kansas, Inc.
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408]*
**Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512
or by fax to (859) 425-3379**

(b) Expedited appeals must be communicated by calling *[(913) 202-5000]* **(800) 245-0618** or by submitting a written fax to *[(866) 769-2408]* **(859) 425-3379, Attention: Appeals Resolution Team.**

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

**Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070**

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*[Express Scripts Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603]*
**Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121**

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have

exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

**HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>**

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; **and**

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; *and*).

[(M) MCHCP may approve appeals of a late submission of a Health Care Provider Form if the subscriber can provide substantiating evidence that the annual wellness exam was received timely, that the subscriber reasonably relied on the health care provider to submit the Health Care Provider Form, and the health care provider failed to submit the Health Care Provider Form prior to the May 31 due date.]

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired

Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership
EMERGENCY AMENDMENT**

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the 2016 Coverage Gap Stage and Catastrophic Coverage Stage annual costs and coinsurance amounts.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach two thousand nine hundred sixty dollars

(\$2,960), the member will pay the following copayments:

A. Generic Formulary Drugs: thirty-one- (31-) day supply has an eight dollar (\$8) copayment; sixty- (60-) day supply has a sixteen dollar (\$16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar (\$24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar (\$20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar (\$35) copayment; sixty- (60-) day supply has a seventy dollar (\$70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar (\$105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent (\$87.50) copayment; and

C. Non-preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment[.];

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[two thousand nine hundred sixty dollars (\$2,960)] three thousand three hundred ten dollars (\$3,310)* and remain below *[four thousand seven hundred dollars (\$4,700)] four thousand eight hundred fifty dollars (\$4,850)*, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[four thousand seven hundred dollars (\$4,700)] four thousand eight hundred fifty dollars (\$4,850)*;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[four thousand seven hundred dollars (\$4,700)] four thousand eight hundred fifty dollars (\$4,850)*, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[two dollar and sixty-five cent (\$2.65)] two dollar and ninety-five cent (\$2.95)* copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a *[six dollar and sixty cent (\$6.60)] seven dollar and forty cent (\$7.40)* copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership
EMERGENCY AMENDMENT**

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (5).

PURPOSE: This amendment removes duplicative language regarding home delivery program copayments and coinsurance amounts, clarifies the specialty drug benefit, updates the term prior authorization to preauthorization, replaces the term physician with provider, and removes unnecessary language regarding step therapy and quantity level limits.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program.

[(a)] *Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;*

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70)

for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;]

[(d)] A member must choose how maintenance prescriptions will be filled by notifying the [pharmacy benefit manager (PBM)] PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

[(I.)(a)] If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum; and

[(II.)(b)] Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. **All specialty prescriptions must be filled through the PBM's specialty pharmacy.** The first fill of a specialty prescription [order] may be filled through a retail pharmacy **if the prescription is identified by the PBM as emergent; /, except for Hepatitis C specialty drugs and those select drugs that have been included in the specialty split-fill program.**

(a) Generic copayment: Eight dollars (\$8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars (\$35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars (\$100) for a drug not on the formulary;]

[(IIII)](a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug which shall not apply to the out-of-pocket maximum; and

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; *[and]*

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—five thousand one hundred dollars (\$5,100);

D. Family—ten thousand two hundred dollars (\$10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d)] A member must choose how maintenance prescrip-

tions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

[(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

[(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and]

(II) Specialty drugs are covered only through [network] the specialty home delivery network for up to a thirty-one- (31-) day/s/ supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy. The first fill of a specialty prescription may be filled through a retail pharmacy if the prescription is identified by the PBM as retail;

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;]

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; *[and]*

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

F. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager] PBM*, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other, more costly therapy, if necessary. The member is responsible for paying the full price for the prescription drug unless the member's [physician] provider prescribes a first-step drug. If the member's [physician] provider decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the [physician] provider may request a [prior authorization] preauthorization from the PBM. If the [prior authorization] preauthorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested [prior authorization] preauthorization is not approved, then the member is responsible for the full price of the drug.

[(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First-step drugs must be attempted before the plan will authorize payment for second-step drugs.

[(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first-step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.]

(5) Quantity Level Limits. Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. *[Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.]*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), (6), and (10), and adding section (14).

PURPOSE: This amendment clarifies the terms and conditions, eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth; employee and dependent effective dates when adding coverage due to a life event, deadline for proof of eligibility documentation, documentation requirements for disabled dependents, documentation required to terminate coverage due to the death of a dependent, requirements for Medicare members, and removes repetitive language regarding addition of dependents.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year.

Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Terms and Conditions. This rule provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). A foster parent and his/her dependents are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by the foster parent and seek recovery and/or pursue legal action to the extent the foster parent has provided incomplete, false, or inaccurate information. *[Purchase of the insurance is at the foster parent's own expense. MCHCP does not contribute toward the premium. The term "foster parent" means any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.]*

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;
2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

- (I) Natural child of subscriber or spouse;
- (II) Legally-adopted child of subscriber or spouse;
- (III) Child legally placed for adoption of subscriber or spouse;
- (IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;
- (V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent after the foster child relationship ends by operation of law when the child ages out if the foster

child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's day of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber; or

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(C) may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. **[MCHCP] The claims administrator** will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(C) An eligible foster parent may apply for coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent and his/her spouse/child(ren) may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for *coverage of* covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. If an eligible foster parent is enrolled in the **PPO 300 or PPO 600 Plan** and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year; or

6. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

7. If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

/6./8. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(4) Effective Date Provisions. In no circumstances can the effective date be before the eligibility date or before January 1, 2013. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Eligible Foster Parent and Dependent Effective Dates.

1. Unless stated otherwise by these rules, an eligible foster parent and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for **[newborns] coverage being added due to a birth, adoption, or placement of children**, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an eligible foster parent enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility, **unless enrollment is received on the first day of a month, in which case coverage is effective on that day;**

B. Newborn.

(I) If a subscriber or eligible foster parent enrolls **[his/her] an eligible newborn [or a subscriber enrolls a newborn of his/her dependent]** within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) **If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject**

to proof of eligibility. The monthly premium will not be prorated.

[(II)](III) If a subscriber does not elect to enroll a newborn of a dependent child within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child due to establishment of paternity within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or eligible foster parent enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or eligible foster parent enrolls a child due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or eligible foster parent enrolls a foster child due to placement in the subscriber or eligible foster parent's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Eligible Foster Parent.

(I) If an eligible foster parent enrolls due to a life event, the effective date for the eligible foster parent is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated.

3. An eligible foster parent who elects coverage and/or changes coverage levels for him/herself and his/her spouse/child(ren) or dependents during open enrollment shall have an effective date of January 1 of the following year.

4. If a foster parent gains state employment, s/he must enroll as a new state employee.

5. Coverage is effective for a dependent the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the *[letter]* date **MCHCP processed the enrollment**, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP,

coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. **If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.**

[(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the spouse/child(ren) not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation within the above stated time frames will result in the spouse/child(ren) being ineligible for coverage until the next open enrollment period;]

[2.](A) When enrolling a newborn, the member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the member of the steps to initiate coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; and].

[3.](B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Addition of biological child(ren)	Government-issued birth certificate or other government-issued or legally-certified proof of paternity listing subscriber as parent and child's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Order of placement
Adoption of dependent(s)	Order of placement; or Filed petition for adoption listing subscriber as adoptive parent (documentation must be received with the enrollment forms) and final adoption decree or birth certificate issued (documentation must be received within thirty-one (31) days of the date the court enters a final decree of adoption)/.
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers (Power of Attorney is not acceptable)
Addition of a child(ren) of covered dependent	Government-issued birth certificate or legally-certified proof of paternity for the child(ren) listing dependent as parent with child's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of persons covered

/(B)/(C) An eligible foster parent and his/her spouse/child(ren) enrolling due to a loss of employer-sponsored group coverage. The foster parent must submit documentation of proof of loss within sixty (60) days of enrollment. Failure to provide the required documentation within the above stated time frames will result in the foster parent and his/her spouse/child(ren) being ineligible for coverage until the next open enrollment period.

/(C)/(D) The eligible foster parent is required to notify MCHCP on the appropriate form of the spouse/child's name, date of birth, eligibility date, and Social Security number.

/(D)/(E) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to

the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and/. Evidence could be from the Social Security Administration (SSA), representation from the dependent's or child's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and/

[C./B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled [by SSA].

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(E) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.]

(6) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make premium payment for the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber and his/her dependents will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Loss of foster parent licensure as determined by the Department of Social Services;

3. With respect to dependents, upon divorce or legal separation from the subscriber or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her enrolled ex-spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

4. Death of dependent. The dependent's coverage ends on the date of death. *The subscriber must submit a completed form and a copy of the death certificate within thirty-one (31) days of death;*

5. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

6. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

7. A subscriber has obtained access to other health insurance coverage through an employer or spouse's employer; or

8. A member otherwise loses benefit eligibility.

(10) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.]

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

(14) Members are required to annually disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will not be processed until the information is received. Once the information is received, claims will be processed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. [2014] 2013. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.150 Disease Management Services Provisions and Limitations. The Missouri Consolidated Health Care Plan is amending the purpose, sections (1), (2), (3), (4), (7), and (8), adding sections (5) and (6), and renumbering as necessary.

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program and, the disease management [incentive, and the diabetes management incentive] rewards; and the method and timeframes in which the requirements of the [incentive] disease management rewards must be completed.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes

made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Disease management services include: disease management and[,] disease management [incentive, and the diabetes management incentive] rewards. Disease management is administered through Missouri Consolidated Health Care Plan's (MCHCP's) disease management vendor. The disease management [incentive and the diabetes management incentive] rewards are administered through the MCHCP Pharmacy Benefit Manager and medical plans in conjunction with [Missouri Consolidated Health Care Plan's (MCHCP)] MCHCP's disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor, has completed one (1) one-on-one call with a DM Nurse, and one (1) of the following occurs:

1. [Is working] Continues to work one-on-one with a DM nurse; or
2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse. [until the DM vendor determines the condition can be managed independently; or]
3. The DM vendor has determined the member does not require one-on-one work with a DM nurse.]

(3) Disease Management [Incentive] Rewards.

(A) Members actively participating in a DM program through MCHCP's DM vendor are eligible to receive the following respective rewards: [reduced non-formulary prescription copayment or coinsurance:

1. PPO 300 Plan or PPO 600 Plan members—

- A. Fifty-five dollars (\$55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;
- B. One hundred ten dollars (\$110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;
- C. One hundred sixty-five dollars (\$165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;
- D. One hundred thirty-seven dollars and fifty cents (\$137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;

2. HSA Plan members—

- A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.

(B) Members actively participating in DM on December 1, 2014 will receive the DM Incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.

(4) Diabetes Management Incentive.

(A) Members with a diagnosis of diabetes confirmed through either claims data or through a provider's certification must complete the following to be eligible to receive the diabetes management incentive:

1. Enroll in the diabetes DM program through MCHCP's DM vendor; and

2. Actively participate in diabetes DM.

(B) Members actively participating in diabetes DM are eligible to receive:

1. Reduced prescription drug copayment or coinsurance for prescriptions directly related to the treatment of diabetes and the listed diabetic supplies at one hundred percent (100%) as specified:]

[A.]1. PPO 300 Plan or PPO 600 Plan members—

[(I)]A. Formulary generic copayment for Diabetes medications: Four dollars (\$4) for up to a thirty-one- (31-) day supply; eight dollars (\$8) for up to a sixty- (60-) day supply; twelve dollars (\$12) for up to a ninety- (90-) day supply through a network retail pharmacy or ten dollars (\$10) for up to a ninety- (90-) day supply through home delivery[.];

[(III)]B. Formulary brand copayment for Diabetes medications: Seventeen dollars and fifty cents (\$17.50) for up to a thirty-one- (31-) day supply; thirty-five dollars (\$35) for up to a sixty- (60-) day supply; fifty-two dollars and fifty cents (\$52.50) for up to a ninety- (90-) day supply through a network retail pharmacy or forty-three dollars and seventy-five cents (\$43.75) for up to a ninety- (90-) day supply through home delivery[.];

[(III)]C. Non-formulary brand copayment for all medications: fifty dollars (\$50) for up to a thirty-one- (31-) day supply; one hundred dollars (\$100) for up to a sixty- (60-) day supply; one hundred fifty dollars (\$150) for up to a ninety- (90-) day supply through a network retail pharmacy or one hundred twenty-five dollars (\$125) for up to a ninety- (90-) day supply through home delivery[.];

[(IV)]D. Formulary [G]glucometer received at a network pharmacy covered at one hundred percent (100%), one (1) per plan year[.];

[(V)]E. Prescribed [F]formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%)[.]; and

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%);

[B.]2. HSA Plan members—

[(I)]A. Formulary generic coinsurance for Diabetes medications: Five percent (5%) after deductible;

[(III)]B. Formulary brand coinsurance for Diabetes medications: Ten percent (10%) after deductible;

[(III)]C. Non-formulary brand coinsurance for all medications: twenty percent (20%) after deductible;

[(IV)]D. Formulary [G]glucometer, received at a network pharmacy covered at one hundred percent (100%) after deductible, one (1) per plan year[.];

[(V)]E. Prescribed [F]formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%) after deductible[.]; and

[2.]F. [Three (3)] Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%) [for PPO Plan members or at one hundred percent (100%)] after deductible [is met for HSA Plan members].

[(5)](4) [The incentives will start no later than thirty (30) days after active participation begins.] DM Rewards shall begin January 1, 2016 and end December 31, 2016.

(5) Eligible members who are participating in a DM program through MCHCP's DM vendor on December 1, 2015 shall begin receiving DM Rewards on January 1, 2016.

(6) Eligible members who are participating in a DM program through MCHCP's DM vendor after December 1, 2015 shall begin receiving DM Rewards the first day of the second month

after the eligible member has completed one (1) one-on-one call with a DM nurse.

[(6)](7) Eligible members failing to actively participate in DM will lose the [disease management incentive or the diabetes management incentive] **DM Rewards** [and will become ineligible for the respective incentive(s)] for the remainder of the year effective the first day of the second month after MCHCP learns the eligible member has stopped participating.

[(7)](8) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of the [disease management incentive and the diabetes management incentive], **DM Rewards** and/or prosecution.

[(8)](9) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.160 Pharmacy Lock-In Program. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies the definition of lock-in, the process for once the PBM determines a member has misutilized pharmacy benefits, eligibility of prescription coverage, and the pharmacy change request address.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the

Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(2) Definitions. The following definitions apply to this program:

(B) Lock-in: The method to limit or restrict a member to [a designated] one (1) network pharmacy designated for the filling of specified prescription medication(s); and

(4) Once the PBM determines a member has misutilized pharmacy benefits, the PBM will [notify the member, and] refer the member to MCHCP's vendor for case management and/. The notification process includes:

(A) The PBM will send a letter [requesting] notifying the member [to select one (1) designated] of their locked-in status. The letter will include the network pharmacy location[,/ designated to fill the specified prescription medication(s).[, from three (3) pharmacy locations identified by the PBM based on the member's demographic area and past prescription fill history;

(B) The member must notify the PBM of his/her pharmacy selection no later than three (3) weeks from the date of the letter;

(C) If the member fails to make a selection, the PBM will choose a pharmacy for the member; and

(D) The PBM will send the member a letter confirming the designated pharmacy and effective date for the lock-in program.]

(5) Once locked-in to a designated network pharmacy, prescriptions for controlled substances and muscle relaxants will only be covered if filled at the designated pharmacy and otherwise eligible for [payment] coverage.

(7) Pharmacy change requests requirements—

(B) Must be submitted in writing to:

[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121

; and

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (31), (56), (57), and (58).

PURPOSE: *This amendment revises the definitions of experimental/investigational/unproven, primary care physician, prior authorization, and provider.*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.*

(31) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

[(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or]

[(C)](B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis./; or

[(D)](C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(56) Primary care *[physician]* **provider** (PCP). An internist, family/general practitioner, *[or]* pediatrician, **or physician assistant or nurse practitioner in any of the practice areas listed in this definition.**

(57) *[Prior authorization]* **Preauthorization.** A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called *[pre-authorization]* **prior authorization**, prior approval, or precer-

tification. The plan may require *[prior authorization]* **preauthorization** for certain services before the member receives them, except in an emergency. *[Prior authorization]* **Preauthorization** is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request *[prior authorization]* **preauthorization**.

(58) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(21). Other providers include, but are not limited to:

(F) Licensed Clinical Social Worker (**LCSW**);

AUTHORITY: *section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (12).

PURPOSE: *This amendment clarifies eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth, employee and dependent effective dates when adding coverage due to a life event, documentation requirements for disabled dependents, and moves notification requirements for Medicare eligible members from the proof of eligibility section to the Medicare section.*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency*

amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree.

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent **is a dependent on the newborn's day of birth or the date the child's paternity was established** and continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependents or an employee rehired after his/her coverage terminates and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date, as determined by the employer. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date and after the waiting period. Except for **[newborns] coverage being added due to a birth, adoption, or placement of child(ren)**, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

B. Newborn.

(I) If a subscriber or employee enrolls **[his/her] an eligible newborn [or a subscriber enrolls a newborn of his/her dependent]** within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber or employee enrolls an eligible spouse and/or child(ren) within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.

[[/]](III) If a subscriber does not elect to enroll a newborn of a dependent child within thirty-one (31) days of birth, s/he cannot enroll the newborn of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

(II) If a subscriber or employee enrolls an eligible spouse and/or child(ren) within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption, or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Employee.

(I) If an employee enrolls due to a life event or loss of employer-sponsored coverage, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated;

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and *[Evidence could be from the Social Security Administration, representation from the dependent's or child's physician, or by sworn statement from the subscriber;*

B. *A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and]*

[C./B. A benefit verification letter dated within the last twelve (12) months from the [Social Security Administration [SSA/]] confirming the child is still considered disabled [by SSA].

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability

ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(G) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.]

(12) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.]

[(C)](B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(C) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the term "prior authorization" to "preauthorization" and clarifies the requirements for preauthorization of physical, speech, and occupational therapy and rehabilitation services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the

*Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) *[Prior Authorization]* **Prauthorization** of Services—The claims administrator must authorize some services in advance. Without *[prior authorization]* **preauthorization**, any claim that requires *[prior authorization]* **preauthorization** will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to *[prior authorization]* **preauthorization** under this rule. *[Prior authorization]* **Prauthorization** does not verify eligibility or payment. *[Prior authorizations]* **Prauthorizations** found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to *[prior authorization]* **preauthorization**:

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric surgery;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. Chiropractic services after twenty-six (26) visits annually;
- H. Cochlear implant device;
- I. Chelation therapy;
- J. Dental care;
- K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;
- L. Genetic testing or counseling;
- M. Hearing Aids;
- N. Home health care;
- O. Hospice care and palliative services;
- P. Hospital inpatient services;
- Q. Imaging (diagnostic non-emergent outpatient), including

magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

R. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

S. Nutritional counseling after six (6) sessions annually;

T. Orthognathic surgery;

U. Orthotics over one thousand dollars (\$1,000);

V. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per *[incident]* **calendar year**;

W. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

X. Prostheses over one thousand dollars (\$1,000);

Y. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Z. Skilled nursing facility;

AA. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

BB. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to *[prior authorization]* **preauthorization**:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; **and**

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy; **and**].

3. *[Prior authorization]* **Prauthorization** timeframes.

A. A benefit determination for non-urgent *[prior authorization]* **preauthorization** requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent *[prior authorization]* **preauthorization** requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another

primary carrier, including Medicare, are not subject to this provision; *[and]*

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation, coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review*[/i];*

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment*[/i>; and*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RESCISSION

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 1000 Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circum-

stances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission covering this same material is published in the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, one thousand dollars (\$1,000); family, three thousand dollars (\$3,000) and for non-network: per individual, two thousand dollars (\$2,000); family, six thousand dollars (\$6,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance;

non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000) and for non-network: per individual, ten thousand dollars (\$10,000); family, thirty thousand dollars (\$30,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer

to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Each subscriber will have access to payment information of the family unit.

(8) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(9) Copayments. Copayments apply to network services unless otherwise specified:

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(10) Usual, customary, and reasonable fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(11) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(12) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(13) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RESCISSION

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify Health Savings Account Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. A proposed rescission covering this same material is published in the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, four thousand dollars (\$4,000); family, eight thousand dollars (\$8,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—three thousand three hundred dollars (\$3,300).
2. Network out-of-pocket maximum for family—six thousand six hundred dollars (\$6,600).
3. Non-network out-of-pocket maximum for individual—five thousand dollars (\$5,000).
4. Non-network out-of-pocket maximum for family—ten thousand dollars (\$10,000).

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutritional counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Newborn's claims will be subject to deductible and coinsurance.

(9) Each subscriber will have access to payment information of the family unit.

(10) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(11) Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months

following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (15) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

(15) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(16) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RESCISSION

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 600 Plan benefit provisions and charges.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission covering this same material is published in the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and

responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Deductible—per calendar year for network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200) and for non-network: per individual, one thousand two hundred dollars (\$1,200); family, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000) and for non-network: per individual, three thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Each subscriber will have access to all payment information of the family unit.

(8) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans during the plan year or continues enrollment under another subscriber's plan within the same plan year.

(9) Copayments—Copayments apply to network services unless otherwise specified.

(A) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(10) Usual, customary, and reasonable limit fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(11) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in

the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(12) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(13) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3); and renumbering as necessary.

PURPOSE: This amendment clarifies the following benefits: allergy testing and immunotherapy, bariatric surgery, contraception and sterilization, durable medical equipment, foot care, genetic counseling, genetic testing, hospice, hospital, preventive services, transplants, and urgent care; corrects the alphabetical order of benefits by moving Bone Growth Stimulators to paragraph (3)(E)4.; and adds coverage of blood pressure cuffs/monitors with a diagnosis of diabetes.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public

entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(3) Covered Charges Applicable to the PPO 600 Plan, PPO 1000, and HSA Plan.

(E) Plan benefits for the PPO 600 Plan, PPO 1000, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. *[No coverage for no provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]* Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

- (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
- (b) Member has a life-threatening allergy to insect stings; or
- (c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and
- (VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

- (a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;
- (b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
- (c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits^[, Ana-Kit, and Epi-Pen kits] to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by **the [one (1) of the following accreditation programs:]**

[(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III)] Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a

mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.); or

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[5.]6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;/. *The following contraceptive devices and injections are covered when administered in a provider's office:*

A. *Available under the medical plan only—*

(I) Tubal ligation;

B. *Available under the prescription or medical plan—*

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;]

[6.]7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

[7.]8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

/8./9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

/9./10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that maybe relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

/10./11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investi-

gational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

/11./12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one

(1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

[12./13. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury;

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

[13./14. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network

provider;

[14./15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

[F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;]

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[15./16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

[16./17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

[17./18. Foot care (trimming of nails, corns, or calluses). *[Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities.]* Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[18./19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are

covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals *[from ethnic groups]* recognized to be at increased risk for *[specific]* genetic disorders *[(e.g., African Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease)]*;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with *[mental retardation]* **intellectual developmental disorders**, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[19.]20. Genetic testing. [No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA).]

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

[A.](I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

[B.](II) The result of the test will directly impact the treatment being delivered to the member;

[C.](III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

[D.](IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;/.]

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[20.]21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[21.]22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[22.]23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A comprehensive medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[23.]24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[24.]25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by, or under the supervision of, a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by, or under the supervision of, a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[25.]26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accruited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by, or under the supervision of, a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within *[six (6) months] twelve (12) months* of death;

[26.]27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstruction services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the med-

ical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services *[not otherwise offered in an outpatient setting]* **provided on less than a full-time inpatient basis.** *[The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week.]* The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; **and**

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility, and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; *[and]*

[(VI) Inpatient treatment in a network hospital or facility by a non-network provider. Inpatient treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;]

[27.]28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

[28./29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[29./30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[30./31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[31./32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[32./33. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[33./34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[34./35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequelae;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviations from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[35./36. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering, or expected to interfere, significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the

patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[36./37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. *[Annual physical]* Preventive exams and routine lab and X-ray services ordered as part of the *[annual]* exam. *[One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.]* For benefits to be covered as preventive, including X-rays and lab services, they must be coded by *[your physician]* the provider as routine, without indication of an injury or illness.

F. Cancer screenings. **One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—**

(I) Mammograms—*[one (1) exam per year,]* no age limit;

(II) Pap smears—*[one (1) per year,]* no age limit;

(III) Prostate—*[one (1) per year,]* no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema. *[per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.]*

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

[37./38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[38./39. Pulmonary rehabilitation. Comprehensive, individual-

ized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[39./40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[40. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

41. Telehealth Services. Telehealth services are covered for the

diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parent(s). The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maxi-

mum. Travel, lodging, and meals are not covered. *[Non-network facility charges and payments for transplants are limited to the following maximums:*

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);]

44. Urgent care. *[Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care]* Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: This amendment adds limitations for the following medical benefits, services, or supplies: genetic counseling, non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning, non-covered drugs, non-reusable disposable supplies, and routine foot care without the presence of systemic disease that affects lower extremities. These items were previously contained in 22 CSR 10-3.057. In addition, this amendment clarifies limitations regarding experimental/investigational/unproven services, procedures, supplies, or drugs; athletic services; physical fitness; and therapy for improvement of athletic performance. Non-medically necessary services was moved to subsection (1)(NN) and services obtained at a government facility if care is provided without charge

was moved to subsection (1)(WW) to correct the alphabetical order of the subsections in section (1).

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise, and then only to the extent expressly provided herein or in 22 CSR 10-3.057.

(F) Athletic [training] enhancement services and sports performance training.

(V) [Experimental or investigational] Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

[(X)] Services obtained at a government facility if care is provided without charge.]

[(Y)](X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

(Y) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(MM) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advanced by the PBM.

(NN) Non-medically necessary services.

(OO) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(PP) Non-reusable disposable supplies.

[(MM)](QQ) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

[(NN)](RR) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

[(OO)](SS) Physical and recreational fitness.

[(PP)](TT) Private-duty nursing.

(UU) Routine foot care without the presence of systemic disease that affects lower extremities.

[(QQ)](VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.

[(RR)] Services not medically necessary.]

(WW) Services obtained at a government facility if care is provided without charge.

[(SS)](XX) Sex therapy.

[(TT)](YY) Surrogacy—pregnancy coverage is limited to plan member.

[(UU)](ZZ) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(VV)](AAA) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance [or for recreation];

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

[(WW)](BBB) Travel expenses.

[(XX)](CCC) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the order of benefit determination rules.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the cir-

cumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan's [has] rules [coordinating its benefits with those of MCHCP; and

2. Both those rules] and MCHCP's rules require MCHCP [benefits be determined before those of the other plan.] to be primary; or

2. The other plan's rules conflict with MCHCP's rules, then the plan that has been in effect the longest is primary.

AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2014] 2013. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment clarifies appeals must be made within one hundred eighty (180) days of issuance of the denial or notice, updates the address for Pharmacy Lock-In Program appeals, and removes references to Coventry Health Care of Kansas, Inc.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated

to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(2) General Appeal Provisions.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of *[receiving]* issuance of the denial or notice which gave rise to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR[, Coventry Health Care of Kansas, Inc.,] and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect, except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective

retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review, except as specifically provided in 22 CSR 10-3/2/.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review

with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

[(VI) For members with medical coverage through Coventry Health Care of Kansas, Inc. —

(a) First and second level appeals must be submitted in writing to—

*Coventry Health Care of Kansas, Inc.
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408*

(b) Expedited appeals must be communicated by calling (913) 202-5000 or by submitting a written fax to (866) 769-2408.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of

the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the

claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (6).

PURPOSE: This amendment removes duplicative language regarding home delivery program copayments and coinsurance amounts, clarifies the specialty drug benefit, updates the term prior authorization to preauthorization, replaces the term physician with provider, and removes unnecessary language regarding step therapy and quantity level limits.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties

under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Home delivery programs—

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program.

[(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary.

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d)] A member must choose how maintenance prescription(s) will be filled by notifying the [pharmacy benefit manager (PBM)] of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

[(e)](a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

[(f)](b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. **All specialty prescriptions must be filled through the PBM's specialty pharmacy.** The first fill of a specialty prescription [order] may be filled through a retail pharmacy **if the prescription is identified by the PBM as emergent;], except for**

Hepatitis C specialty drugs and those select drugs that have been included in the specialty split-fill program.

(a) Generic copayments: Eight dollars (\$8) for a generic drug on the formulary list.

(b) Brand copayments: Thirty-five dollars (\$35) for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars (\$100) for a drug not on the formulary;]

[(III)](a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, and up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug which shall not apply to the out-of-pocket maximum.

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars (\$5,100).

D. Family—ten thousand two hundred dollars (\$10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d)] A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

[(e)](a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

[(f)](b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to thirty-one (31) days.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.]

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%)

when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

F. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the [pharmacy benefit manager] PBM, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. The member is responsible for paying the full price for the prescription drug unless the member's [physician] provider prescribes a first-step drug. If the member's [physician] provider decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the [physician] provider may request a [prior authorization] preauthorization from the PBM. If the [prior authorization] preauthorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested [prior authorization] preauthorization is not approved, then the member is responsible for the full price of the drug.

[(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First-step drugs must be attempted before the plan will authorize payment for second-step drugs.

[(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first-step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.]

(6) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. [Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.]

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.150 Disease Management Services Provisions and Limitations. The Missouri Consolidated Health Care Plan is amending the purpose, sections (1), (2), (3), (4), (7), and (8), adding sections (5) and (6), and renumbering as necessary.

PURPOSE: This amendment changes the disease management and diabetes management incentives to Disease Management Rewards and clarifies participation requirements, benefits, and copayments and coinsurance amounts.

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program and[,] the disease management [incentive, and the diabetes management incentive] rewards; and the method and timeframes in which the requirements of the [incentive] disease management rewards must be completed.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.

(1) Disease management services include: disease management and[,] disease management [incentive, and the diabetes management incentive] rewards. Disease management is administered through Missouri Consolidated Health Care Plan's (MCHCP's) disease management vendor. The disease management [incentive and the diabetes management incentive] rewards are administered through the MCHCP Pharmacy Benefit Manager and medical plans in conjunction with [Missouri Consolidated Health Care Plan's ([MCHCP's])] disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor, **has completed one (1) one-on-one call with a DM nurse** and one (1) of the following occurs:

1. *[Is working]* **Continues to work** one-on-one with a DM nurse;
2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse *[until the DM vendor determines the condition can be managed independently; or*
3. *The DM vendor has determined the member does not require one-on-one work with a DM nurse].*

(3) Disease Management *[Incentive]* Rewards.

(A) Members actively participating in a DM program through MCHCP's DM vendor are eligible to receive the following respective rewards *[reduced non-formulary prescription copayment or coinsurance]*:

- [1. PPO 600 Plan or PPO 1000 Plan members—*
 - A. Fifty-five dollars (\$55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;
 - B. One hundred ten dollars (\$110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;
 - C. One hundred sixty-five dollars (\$165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;
 - D. One hundred thirty-seven dollars and fifty cents (\$137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;
 - 2. HSA Plan members—*
 - A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.
- (B) *Members actively participating in DM on December 1, 2014 will receive the DM incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.]*

1. PPO 600 Plan or PPO 1000 Plan members—

A. Formulary generic copayment for diabetes medications: four dollars (\$4) for up to a thirty-one- (31-) day supply; eight dollars (\$8) for up to a sixty- (60-) day supply; twelve dollars (\$12) for up to a ninety- (90-) day supply through a network retail pharmacy or ten dollars (\$10) for up to a ninety- (90-) day supply through home delivery;

B. Formulary brand copayment for diabetes medications: seventeen dollars and fifty cents (\$17.50) for up to a thirty-one- (31-) day supply; thirty-five dollars (\$35) for up to a sixty- (60-) day supply; fifty-two dollars and fifty cents (\$52.50) for up to a ninety- (90-) day supply through a network retail pharmacy or forty-three dollars and seventy-five cents (\$43.75) for up to a ninety- (90-) day supply through home delivery;

C. Non-formulary brand copayment for all medications: fifty dollars (\$50) for up to a thirty-one- (31-) day supply; one hundred dollars (\$100) for up to a sixty- (60-) day supply; one hundred fifty dollars (\$150) for up to a ninety- (90-) day supply through a network retail pharmacy or one hundred twenty-five dollars (\$125) for up to a ninety- (90-) day supply through home delivery;

D. Formulary glucometer received at a network pharmacy covered at one hundred percent (100%), one (1) per plan year;

E. Prescribed formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%);

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%).

2. HSA Plan members—

A. Formulary generic coinsurance for diabetes medications: five percent (5%) after deductible;

B. Formulary brand coinsurance for diabetes medications: ten percent (10%) after deductible;

C. Non-formulary brand coinsurance for all medications: twenty percent (20%) after deductible;

D. Formulary glucometer, received at a network pharmacy covered at one hundred percent (100%) after deductible, one (1) per plan year;

E. Prescribed formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%) after deductible;

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%) after deductible.

(4) *[The incentives will start no later than thirty (30) days after active participation begins.]* DM Rewards shall begin January 1, 2016 and end December 31, 2016.

(5) Eligible members who are participating in a DM program through MCHCP's DM vendor on December 1, 2015 shall begin receiving DM Rewards on January 1, 2016.

(6) Eligible members who are participating in a DM program through MCHCP's DM vendor after December 1, 2015 shall begin receiving DM Rewards the first day of the second month after the eligible member has completed one (1) one-on-one call with a DM nurse.

[(5)](7) Eligible members failing to actively participate in DM will lose *[the disease management incentive or the diabetes management incentive and will become ineligible for the respective incentive(s)]* DM Rewards for the remainder of the year effective the first day of the second month after MCHCP learns the eligible member has stopped participating.

[(6)](8) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of *[the disease management incentive and the diabetes management incentive]* DM Rewards, and/or prosecution.

[(7)](9) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.160 Pharmacy Lock-In Program. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies the definition of lock-in, the process for once the PBM determines a member has misutilized pharmacy benefits, eligibility of prescription coverage, and the pharmacy change request address.

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2016, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2015, becomes effective January 1, 2016, and expires June 28, 2016.*

(2) Definitions. The following definitions apply to this program:

(B) Lock-in: The method to limit or restrict a member to *[a designated]* **one (1) network pharmacy designated** for the filling of specified prescription medication(s); and

(4) Once the PBM determines a member has misutilized pharmacy benefits, the PBM will *[notify the member and]* refer the member to MCHCP's vendor for case management. *[The notification process includes:]*

[(A) The PBM] will send a letter [requesting] notifying the member [to select one (1) designated] of their locked-in status. The letter will include the network pharmacy location designated to fill the specified prescription medication(s). [from three (3) pharmacy locations identified by the PBM based on the member's demographic area and past prescription fill history;

(B) The member must notify the PBM of his/her pharmacy selection no later than three (3) weeks from the date of the letter;

(C) If the member fails to make a selection, the PBM will choose a pharmacy for the member; and

(D) The PBM will send the member a letter confirming the designated pharmacy and effective date for the lock-in program.]

(5) Once locked-in to a designated network pharmacy, prescriptions for controlled substances and muscle relaxants will only be covered if filled at the designated pharmacy and otherwise eligible for *[payment]* coverage.

(7) Pharmacy change request requirements—

(B) Must be submitted in writing to:

*[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

; and

AUTHORITY: *section 103.059, RSMo 2000. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbolology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:

Boldface text indicates new matter.

[Bracketed text indicates matter being deleted.]

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 30—Office of the Director
Chapter 12—Forensic Examinations**

PROPOSED RULE

11 CSR 30-12.020 Payments for Child Physical Abuse Forensic Examinations

PURPOSE: This rule sets out the requirements of submitting a claim for payment, establishes the criteria by which expenses are paid, and sets out the maximum payment for SAFE-CARE providers who perform or provide a case review of a forensic examination of a person under eighteen (18) years of age who is an alleged victim of physical abuse.

(1) For purposes of this section, the following terms mean:

(A) "Child abuse medical resource centers" - medical institutions affiliated with accredited children's hospitals or recognized institutions of higher education with accredited medical school programs that provide training, support, mentoring, and peer review to SAFE-CARE providers in Missouri;

(B) "SAFE-CARE provider" - a physician, advanced practice nurse, or physician's assistant licensed in this state who provides medical diagnosis and treatment to children suspected of being victims of abuse and who receives—

1. Missouri-based initial intensive training regarding child maltreatment from the SAFE-CARE network;

2. Ongoing update training on child maltreatment from the SAFE-CARE network; and

3. Peer review and new provider mentoring regarding the forensic evaluation of children suspected of being victims of abuse from the SAFE-CARE network;

(C) "Sexual assault forensic examination child abuse resource education network" or "SAFE-CARE network" - a network of SAFE-CARE providers and child abuse medical resource centers that collaborate to provide forensic evaluations, medical training, support, mentoring, and peer review for SAFE-CARE providers for the medical evaluation of child abuse victims in this state to improve outcomes for children who are victims of or at risk for child maltreatment by enhancing the skills and role of the medical provider in a multidisciplinary context;

(D) "Child physical abuse forensic examination" - a physical examination performed on an alleged victim of physical abuse who is under eighteen (18) years of age by a SAFE-CARE provider to collect and preserve evidence;

(E) "Case Review" - a written record review or evaluation of previously gathered photographs, medical records, including, but not limited to, radiology and laboratory tests, medical chart documentation, and investigative information including, but not limited to, information provided by a multi-disciplinary team, Missouri Children's Division, law enforcement, or juvenile authorities; and

(F) "Department" - the Missouri Department of Public Safety.

(2) All claims for reimbursement of a child physical abuse forensic examination shall be submitted to the department's Child Physical Abuse Forensic Examination Program as a payor of first resort within ninety (90) days of the child physical abuse forensic examination. All claims for reimbursement of case reviews shall be submitted within one hundred eighty (180) days after the child physical abuse forensic examination. The department shall only reimburse professional fees to SAFE-CARE providers who perform a child physical abuse forensic examination or professional fees to SAFE-CARE providers who provide a case review of a child physical abuse forensic examination. The department shall not reimburse providers for medical procedures, facility fees, supplies, laboratory/radiology tests, court preparation, or court testimony.

(3) All claims for reimbursement shall be made on the Child Physical Abuse Forensic Examination form. The SAFE-CARE provider must ensure that all fields of the claim form are completely and legibly filled out. If the claim form is incomplete or unsigned, the claim may be rejected or denied.

(4) The Child Physical Abuse Forensic Examination form must include all applicable signatures, including consent or authorization for the child physical abuse forensic examination as well as the signature of the SAFE-CARE provider who performed the child physical abuse forensic examination and/or the signature of the SAFE-CARE provider who performed the case review, if applicable.

(5) All claims for reimbursement shall include an itemized billing invoice which includes appropriate charge amounts for the child

physical abuse forensic examination or case review including the accompanying current International Classification of Disease (ICD) code(s). Written explanation and reasoning may be required to justify certain codes.

(6) The itemized billing statement must include at least one (1) of the following ICD diagnosis codes as applicable:

(A) With forensic findings—

1. Child abuse, unspecified - 995.50
2. Child physical abuse - 995.54
3. Shaken infant syndrome - 995.55
4. Other child abuse and neglect - 995.59; or

(B) With no forensic findings—

1. Observation following other inflicted injury - V71.6
2. Abuse and neglect - V71.81.

(7) Maximum reimbursement for eligible claims shall be—

(A) Seven hundred fifty dollars (\$750.00) for a child physical abuse forensic examination; or

(B) Four hundred dollars (\$400.00) for a case review of the child physical abuse forensic examination.

(8) Professional fee charges for the child physical abuse forensic examination or case review shall not be billed to other payment resources, such as the patient's parent or guardian, health insurance, Medicaid, or Medicare.

(9) If the same SAFE-CARE provider performs both the child physical abuse forensic examination and the case review on the same child, such provider cannot be reimbursed for both, but may be reimbursed for one (1) if all criteria are met.

(10) Only one (1) child physical abuse forensic examination per report of physical abuse on an alleged victim may be reimbursed and no reimbursement will be made for any subsequent exam on the same victim. Reimbursement will not be made for more than one (1) case review per report of physical abuse and no reimbursement will be made for any subsequent case review for the same victim.

(11) In the event that the child has been the victim of both physical and sexual abuse, the department will reimburse one (1) forensic examination performed per report of abuse, whether sexual, physical, or both. A claim for reimbursement may be submitted to only one (1) program, either the Child Physical Abuse Forensic Examination Program or the Sexual Assault Forensic Examination (SAFE) Program.

(12) For a claim to be eligible for reimbursement by the Child Physical Abuse Forensic Examination Program—

(A) The alleged physical abuse incident must have occurred in Missouri; or

(B) The alleged victim of physical abuse must be a Missouri resident.

(13) The department, at its discretion, may require additional information regarding the child physical abuse forensic examination or case review for auditing purposes.

AUTHORITY: section 334.950, RSMo Supp. 2014. Emergency rule filed Nov. 2, 2015, effective Nov. 12, 2015, expires May 9, 2016. Original rule filed Nov. 2, 2015.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions seven hundred eighty-three dollars (\$783) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Public Safety, PO Box 749, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**FISCAL NOTE
PUBLIC COST**

- I. Department Title: Department of Public Safety**
Division Title: Office of the Director
Chapter Title: Forensic Examinations

Rule Number and Name:	11 CSR 30-12.020
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Public Safety	\$783.00

III. WORKSHEET

Dell Optiplex 7020 SFF 8GB memory with Integrated Graphics, i5-4690 Processor, 500GB hard drive	\$599.00
Dell CFI, Rollup, Integration Service, Image Load n/a	\$ 14.00
23" LCD Widescreen Flat-Panel Monitor	\$160.00
Asset Tagging with Electronic Inventory Reporting:	\$ 10.00
TOTAL	\$783.00

IV. ASSUMPTIONS

DPS was appropriated \$1,422,000 to comply with section 334.950, RSMo Supp. 2014 that instructs DPS to make payments to SAFE-CARE providers who provide forensic examinations of persons under eighteen years of age who are alleged victims of physical abuse. An additional \$30,000 was also appropriated for salary and benefits for an FTE.

Items not covered by the appropriations include a computer hard drive and monitor.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions**

PROPOSED AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The director of revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2016.

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governor's of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year, has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%

*AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 22, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 22, 2015.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in no change to the interest rate charged on delinquent taxes from that of 2015.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in no change in the interest rate charged on delinquent taxes from that of 2015. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, Legal Services Division, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE
PUBLIC COST****I. RULE NUMBER**

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	Because the 2016 interest rate imposed on delinquent taxes will be at the same rate imposed in 2015, the aggregate impact on public entities will be less than \$500.
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment sets the rate of interest for 2016 at 3%, the same rate as 2015.

The future amount of past due taxes is unknown. Because the 2016 interest rate imposed on delinquent taxes will be the same rate imposed in 2015, there will be no additional fiscal impact for public entities.

	Current Rule – 3%	Proposed Amendment – 3%
Past due tax amount	\$100.00	\$100.00
Interest amount	3.00%	3.00%
Total Amount Due	\$103.00	\$103.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2015 was 3.25 percent. Rounded to the nearest whole percentage results in a 3 percent interest rate.

**FISCAL NOTE
PRIVATE COST**

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	Because the 2016 interest rate imposed on delinquent taxes will be the same rate imposed in 2015, the aggregate impact on private entities will be less than \$500.

III. WORKSHEET

The proposed amendment sets the rate of interest for 2016 at 3%, the same rate as 2015.

The future amount of past due taxes is unknown. Because the 2016 interest rate imposed on delinquent taxes will be the same rate imposed in 2015, there will be no additional cost to private entities.

	Current Rule – 3%	Proposed Amendment – 3%
Past due tax amount	\$100.00	\$100.00
Interest amount	3.00%	3.00%
Total Amount Due	\$103.00	\$103.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2015 was 3.25 percent. Rounded to the nearest whole percentage results in a 3 percent interest rate.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 2255—Missouri Board for Respiratory Care
Chapter 1—General Rules**

PROPOSED AMENDMENT

20 CSR 2255-1.040 Fees. The board is amending subsections (1)(A), (1)(B), (1)(C), (1)(H), and (1)(J).

PURPOSE: The board is proposing to decrease fees associated with licensure.

(1) The following fees are established by the Division of Professional Registration:

(A) Application for Licensure as a Respiratory Care Practitioner (Including Reciprocity Applications)	\$/65.00 / 55.00
(B) Application for Temporary Permit	\$/50.00 / 40.00
(C) Application for an Educational Permit	\$/25.00 / 15.00
(H) Biennial License Renewal Fee	\$/50.00 / 30.00
(J) Biennial Inactive License Renewal Fee	\$/30.00 / 20.00

AUTHORITY: section[s] 334.840.2, RSMo 2000, and section 334.850, RSMo Supp. 2013. This rule originally filed as 4 CSR 255-1.040. Emergency rule filed June 25, 1998, effective July 6, 1998, expired Feb. 25, 1999. Original rule filed June 25, 1998, effective Jan. 30, 1999. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 2, 2015.

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately forty-two thousand five hundred twenty dollars (\$42,520) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities approximately forty-two thousand five hundred twenty dollars (\$42,520) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board for Respiratory Care, Attention: Vanessa Beauchamp, PO Box 1335, Jefferson City, MO 65102, by facsimile to (573) 526-3489, or via email to rcp@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions, and Professional Registration

Division 2255 - Missouri Board for Respiratory Care

Chapter 1 - General Rules

PROPOSED AMENDMENT

20 CSR 2255-1.040 Fees

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
Missouri Board for Respiratory Care		\$42,520.00
	Total Loss of Revenue Biennially for the Life of the Rule	\$42,520.00

III. WORKSHEET

See Private Entity Fiscal Note.

IV. ASSUMPTION

1. The total loss of revenue is based on the cost savings to private entities reflected in the Private Fiscal Note filed with this rule.

PRIVATE ENTITY FISCAL NOTE**I. RULE NUMBER****Title 20 - Department of Insurance, Financial Institutions, and Professional Registration****Division 2255 - Missouri Board for Respiratory Care****Chapter 1 - General Rules****PROPOSED AMENDMENT****20 CSR 2255-1.040 Fees****II. SUMMARY OF FISCAL IMPACT**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated biennial cost savings with compliance of the amendment by affected entities:
640	Respiratory Care Practitioner Application Fee - \$10 Decrease	\$6,400.00
2	Respiratory Care Practitioner Temporary Permit Fee - \$10 Decrease	\$20.00
50	Respiratory Care Practitioner Educational Permit Fee - \$10 Decrease	\$500.00
1,710	Respiratory Care Practitioner Renewal Fee - \$20 Decrease	\$34,200.00
140	Respiratory Care Practitioner Inactive Renewal Fee - \$10 Decrease	\$1,400.00
	Estimated Biennial Cost Savings for the Life of the Rule	\$42,520.00

III. WORKSHEET

See table above.

IV. ASSUMPTIONS

1. Based on FY15 actuals, the board estimates approximately 320 new licensees, 1 temporary permit licensee, and 25 educational permit licensees will apply for licensure annually; 70 inactive respiratory care practitioners will renew their licenses annually; and approximately 1,710 active respiratory care practitioners will renew their licenses biennially.
2. It is anticipated that the total savings will recur biennially for the life of the rule, may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.
3. The Missouri Board for Respiratory Care is statutorily obligated to enforce and administer the provisions of sections 334.850, RSMo. Pursuant to section 334.850, RSMo, the board shall set by rule the appropriate amount of fees so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the committee for administering the provisions of Chapter 334.800-334.930, RSMo. Therefore, the board is reducing the fees associated with renewal.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (33), (54), (60), (61), and (62), adding section (35), and renumbering as necessary.

PURPOSE: This amendment revises definitions for experimental/investigational/unproven, primary care physician, prior authorization, and provider; revises a section reference in the definition of participant; and adds a definition for foster parent.

(33) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

[(B)] Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

[(C)](B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis; or

[(D)](C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(35) Foster parent. Any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.

[(35)](36) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

[(36)](37) Health assessment (HA). An online questionnaire about a member's health and lifestyle habits required for participation in the *Strive for Wellness*® Partnership Incentive.

[(37)](38) Health Savings Account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

[(38)](39) Health Savings Account (HSA) Plan. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(39)](40) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

[(40)](41) Incident. A definite and separate occurrence of a condition.

[(41)](42) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

[(42)](43) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

[(43)](44) Long-term disability subscriber. A subscriber eligible for long-term disability coverage from Missouri State Employees' Retirement System (MOSERS), Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), or another retirement system whose members are grandfathered for coverage under the plan by law.

[(44)](45) MCHCPid. An individual MCHCP subscriber identifier used for member verification and validation.

[(45)](46) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, retrieve and send secure messages, upload documents, and access health plan websites.

[(46)](47) Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are—

(A) Expected to be of clear clinical benefit to the member;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;

(C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

[(47)](48) Medicare-allowed amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

[(48)](49) Medicare Prescription Drug Plan (PDP). The Medicare Prescription Drug Plan, administered by Express Scripts Medicare PDP, is a Medicare Part D Plan with additional coverage to ensure Medicare members have similar benefits to non-Medicare members.

[(49)](50) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(50)](51) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

[(51)](52) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

[(52)](53) Non-network. The facilities, providers, and suppliers the

health plan does not contract with to provide health care services.

[(53)](54) Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

[(54)](55) Participant. Shall have the same meaning as the term member defined herein (see member, section **[(49)](50)**).

[(55)](56) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

[(56)](57) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

[(57)](58) Plan year. The period of January 1 through December 31.

[(58)](59) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

[(59)](60) Premium. The monthly amount that must be paid for health insurance.

[(60)](61) Primary care *[physician]* **provider** (PCP). An internist, family/general practitioner, *[or]* pediatrician, **or physician assistant or nurse practitioner in any of the practice areas listed in this definition.**

[(61)](62) *[Prior authorization]* **Prior authorization.** A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called *[preauthorization]* **prior authorization**, prior approval, or precertification. The plan may require *[prior authorization]* **preauthorization** for certain services before the member receives them, except in an emergency. *[Prior authorization]* **Prior authorization** is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request *[prior authorization]* **preauthorization.**

[(62)](63) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(22). Other providers include, but are not limited to:

- (A) Audiologist (AUD or PhD);
- (B) Certified Addiction Counselor for Substance Abuse (CAC);
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
- (D) Certified Social Worker or Masters in Social Work (MSW);
- (E) Chiropractor;
- (F) Licensed Clinical Social Worker (LCSW);
- (G) Licensed Professional Counselor (LPC);
- (H) Licensed Psychologist (LP);
- (I) Nurse Practitioner (NP);
- (J) Physician Assistant (PA);
- (K) Occupational Therapist;
- (L) Physical Therapist;
- (M) Speech Therapist;

- (N) Registered Nurse Anesthetist (CRNA);
- (O) Registered Nurse Practitioner (ARNP); or
- (P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

[(63)](64) Prudent layperson. An individual possessing an average knowledge of health and medicine.

[(64)](65) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

[(65)](66) Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

[(66)](67) Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

[(67)](68) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

[(68)](69) Specialty medications. High-cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

[(69)](70) State. Missouri.

[(70)](71) Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

[(71)](72) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

[(72)](73) Subscriber. The person who elects coverage under the plan.

[(73)](74) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

[(74)](75) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

[(75)](76) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(76)](77) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

[(77)](78) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

[(78)](79) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(79)](80) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(80)](81) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth, employee and dependent effective dates when adding coverage due to a life event, deadline for proof of eligibility documentation, documentation requirements for disabled dependents, premium payment deadlines for Medicare primary members, documentation required to terminate coverage due to the death of a dependent, and removes repetitive language regarding addition of dependents.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

B. Active Employee Coverage of a Spouse.

(I) If both spouses are active state employees covered by

MCHCP, each spouse must enroll separately.

C. Retiree Coverage of a Spouse.

(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP.

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent is a **dependent on the newborn's date of birth or the date the child's paternity was established** and continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31)

days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee/eligible variable-hour employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES or another designated enrollment system. Except at initial employment or when identified as an eligible variable-hour employee, an employee and his/her dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for *[newborns]* coverage being added due to a birth, adoption, or placement of children, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP. In no case, shall an eligible variable-hour employee and his/her dependents' coverage begin before January 1, 2015.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

B. Newborn.

(I) If a subscriber or employee enrolls *[his/her]* an eligible newborn *[or a subscriber enrolls a newborn of his/her dependent]* within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.

[[/]](III) If a subscriber does not elect to enroll a newborn of a dependent **child** within thirty-one (31) days of birth, s/he cannot enroll the newborn of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption~~[/]~~.

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption, or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless

enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Employee.

(I) If an employee enrolls due to a life event or loss of employer-sponsored coverage, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before the participation in MCHCP coverage terminates, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event **or loss of employer-sponsored coverage**.

5. An employee who terminates all employment with the state and is rehired in the following month and his/her eligible dependent(s) who were covered by the plan may choose to have continuous coverage or coverage the first of the month after his/her hire date if an enrollment form is submitted within thirty-one (31) days of hire date.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

6. An employee who transfers in the same month from a state agency with MCHCP benefits to another agency with MCHCP benefits, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage. The employee must inform the former agency of the transfer in lieu of a termination. The employee will be transferred through eMCHCP by the former state agency's human resource or payroll representative to the new state agency.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

7. For continuous coverage, an active employee who terminates employment with the state may transfer coverage of him/herself and his/her dependents, **if eligible**, to his/her spouse **or parent** who is an MCHCP subscriber if the spouse **or parent** completes an Enroll/Change/Cancel form within thirty-one (31) days of coverage termination of the active employee's employment.

8. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

A. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

9. A state employee who has medical coverage under MCHCP and transfers state employment to MoDOT, Missouri State Highway Patrol, or the Department of Conservation and his/her dependents are no longer eligible for MCHCP coverage. MCHCP medical coverage is terminated the last day of the month of the employee's termination.

10. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the *[letter]* date **MCHCP processed the enrollment**, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. **If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.**

(A) *[Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the spouse/child(ren) not having coverage until such proof is received, subject to the following:*

1. *If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility;*

2. *When enrolling a newborn, the member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the member of the steps to initiate coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety*

(90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; and (G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years **and** may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence **from the Social Security Administration (SSA)** that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; **and** *Evidence could be from the Social Security Administration, representation from the dependent's or child's physician, or by sworn statement from the subscriber;*

B. *A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and*

C. *B. A benefit verification letter dated within the last twelve (12) months from the [Social Security Administration (SSA)] confirming the child is still considered disabled [by SSA].*

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage.

A. **Non-Medicare primary subscribers**—If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber and his/her dependents will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period[;].

B. **Medicare primary subscribers**—If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to active employee(s) and his/her dependents, the employer has determined that the active employee is no longer an eligible variable-hour employee;

5. With respect to dependents, upon divorce or legal separation from the subscriber or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her enrolled ex-spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise

receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

6. Death of dependent. The dependent's coverage ends on the date of death/. *The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death*;

7. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

8. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP; or

9. A member otherwise loses benefit eligibility.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (8) and (9).

PURPOSE: This amendment clarifies payroll deductions for past-due premiums and removes language regarding double deductions.

(8) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes *[past-due]* premiums *[the payroll deductions for current premiums along with the]* **outside the current month**, payroll deductions for *[past-due]* **all other** premiums **owed** will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars (\$50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars (\$51) to one hundred dollars (\$100) will be deducted from two (2) payrolls;

C. One hundred one dollars (\$101) to two hundred dollars (\$200) will be deducted from three (3) payrolls;

D. Two hundred one dollars (\$201) to three hundred dollars (\$300) will be deducted from four (4) payrolls;

E. Three hundred one dollars (\$301) to four hundred dollars (\$400) will be deducted from five (5) payrolls;

F. Four hundred one dollars (\$401) to five hundred dollars (\$500) will be deducted from six (6) payrolls;

G. Five hundred one dollars (\$501) to six hundred dollars (\$600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars (\$601) to seven hundred dollars (\$700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars (\$701) to eight hundred **dollars** (\$800) *[dollars]* will be deducted from nine (9) payrolls;

J. Eight hundred one dollars (\$801) to nine hundred dollars (\$900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars (\$901) to one thousand dollars (\$1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars (\$1,001) and over will be deducted from twelve (12) payrolls.

4. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums *[will be divided equally and taken from the subscriber's future payrolls as follows:]* **may be taken at the discretion of the employer.**

[(I) One hundred dollars (\$100) or less, deduction will be taken from one (1) payroll;

(II) One hundred one dollars (\$101) to three hundred dollars (\$300) will be deducted from two (2) payrolls;

(III) Three hundred one dollars (\$301) to five hundred dollars (\$500) will be deducted from three (3) payrolls;

(IV) Five hundred one dollars (\$501) to seven hundred dollars (\$700) will be deducted from four (4) payrolls;

(V) Seven hundred one dollars (\$701) to nine hundred dollars (\$900) will be deducted from five (5) payrolls; and

(VI) Nine hundred one dollars (\$901) and over will be deducted from six (6) payrolls.]

2. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(9) Premium Payments.

(A) By enrolling in coverage under MCHCP, an active employee agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. *[Double deductions may be taken to pay for the first month's coverage depending on the date the enrollment is received and the effective date of coverage.]* Subsequent premium payments are deducted from the active employee's paycheck. If the active

employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the term "prior authorization" to "preauthorization" and clarifies the requirements for preauthorization of physical, speech, and occupational therapy and rehabilitation services.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) *[Prior Authorization of Services] Preauthorization*—The claims administrator must authorize some services in advance. Without *[prior authorization] preauthorization*, any claim that requires *[prior authorization] preauthorization* will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to *[prior authorization] preauthorization* under this rule. *[Prior authorization] Preauthorization* does not verify eligibility or payment. *[Prior authorizations] Preauthorizations* found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to *[prior authorization] preauthorization*:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care;

K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

L. Genetic testing or counseling;

M. Hearing Aids;

N. Home health care;

O. Hospice care and palliative services;

P. Hospital inpatient services;

Q. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

R. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

S. Nutritional counseling after six (6) sessions annually;

T. Orthognathic surgery;

U. Orthotics over one thousand dollars (\$1,000);

V. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per *[incident] calendar year*;

W. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

X. Prostheses over one thousand dollars (\$1,000);

Y. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Z. Skilled nursing facility;

AA. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

BB. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to *[prior authorization] preauthorization*:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy; and/.

3. *[Prior authorization] Preauthorization* timeframes.

A. A benefit determination for non-urgent *[prior authorization] preauthorization* requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar

days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent *[prior authorization]* **preauthorization** requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision; *[and]*

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review*[/]*;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment*[/]*; **and**

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 300 Plan benefit provisions and charges.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed

Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, three hundred dollars (\$300); family, six hundred dollars (\$600) and for non-network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family three thousand dollars (\$3,000) and for non-network: per individual, three thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling; and

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit.

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(11) Usual, customary, and reasonable fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RESCISSION

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: *This rule is being rescinded and readopted to clarify PPO 600 Plan benefit provisions and charges.*

AUTHORITY: *section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.*

PUBLIC COST: *This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RULE

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible—per calendar year for network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200) and for non-network: per individual, one thousand two hundred dollars (\$1,200); family, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which

applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000) and for non-network: per individual, three thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to all payment information of the family unit.

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans during the plan year or continues enrollment under another subscriber's plan within the same plan year.

(10) Copayments—Copayments apply to network services unless otherwise specified.

(A) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(11) Usual, customary, and reasonable limit fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RESCISSION

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify the Health Savings Account Plan benefit provisions and charges.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RULE

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, four thousand dollars (\$4,000); family, eight thousand dollars (\$8,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—three thousand three hundred dollars (\$3,300);

2. Network out-of-pocket maximum for family—six thousand six hundred dollars (\$6,600);

3. Non-network out-of-pocket maximum for individual—five thousand dollars (\$5,000); and

4. Non-network out-of-pocket maximum for family—ten thousand dollars (\$10,000).

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service

in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutritional counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Newborn's claims will be subject to deductible and coinsurance.

(9) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(10) Each subscriber will have access to payment information of the family unit.

(11) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(12) Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(13) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(14) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(15) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(16) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (19) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

(17) If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.

(18) If a subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber must enroll in a non-HSA Plan within thirty-one (31) days of notice from MCHCP. If no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan.

(19) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(20) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar (\$300) contribution to each spouse to total maximum six hundred dollars (\$600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	\$300.00	\$600.00
April (delayed contribution due to health care FSA grace period)	\$300.00	\$600.00
All others	A proration of \$300	A proration of \$600

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3); and renumbering as necessary.

PURPOSE: *This amendment clarifies the following benefits: allergy testing and immunotherapy, bariatric surgery, contraception and sterilization, durable medical equipment, foot care, genetic counseling, genetic testing, hospice, hospital, preventive services, transplants, and urgent care; corrects the alphabetical order of benefits by moving Bone Growth Stimulators to paragraph (3)(E)4.; and adds coverage of blood pressure cuffs/monitors with a diagnosis of diabetes.*

(3) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HSA Plan.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. *[No coverage for no provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]* Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, *[Ana-Kit, and Epi-Pen kits]* to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the

[one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness

for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[5.]6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity[.]; [The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;]

[6.]7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

[7.]8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

/8./9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

/9./10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

/10./11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any

disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

/11./12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

[12./13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

[13./14. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider.

[14./15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

[F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;]

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[15./16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

[16./17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

[17./18. Foot care (trimming of nails, corns, or calluses). *[Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities.]* Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[18./19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals *[from ethnic groups]* recognized to be at increased risk for *[specific]* genetic disorders *[(e.g., African Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease)]*;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with *[mental retardation]* **intellectual developmental disorders**, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[19.]20. Genetic testing. *[No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA).]*

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

[A.](I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

[B.](II) The result of the test will directly impact the treatment being delivered to the member;

[C.](III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

[D.](IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[20.]21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[21.]22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[22.]23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may

affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[23.]24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[24.]25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[25.]26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within *[six (6) months]* **twelve (12) months** of death;

[26.]27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental

health services means a day treatment program that offers intensive, multidisciplinary services *[not otherwise offered in an outpatient setting]* **provided on less than a full-time basis.** *[The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week.]* The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; **and**

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; *and*

[(VII) Inpatient treatment in a network hospital or facility by a non-network provider. Inpatient treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;]

[27.]28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Idiopathic progressive polyneuropathy;

[28.]29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition.

Professional charges for automated lab services performed by an out-of-network provider are not covered;

[29./30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home.

[30./31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[31./32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[32./33. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[33./34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[34./35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[35./36. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal

shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;
 (II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[36.]37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. *[Annual physical]* **Preventive** exams and routine lab and X-ray services ordered as part of the *[annual]* exam. *[One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.]* For benefits to be covered as preventive, including X-rays and lab services, they must be coded by *[your physician]* **the provider** as routine, without indication of an injury or illness.

F. Cancer screenings. **One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—**

(I) Mammograms—*[one (1) exam per year,]* no age limit;

(II) Pap smears—*[one (1) per year,]* no age limit;

(III) Prostate—*[one (1) per year,]* no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema *[per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.]*

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

[37.]38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[38.]39. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction,

cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[39.]40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[40. *Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:*

A. *Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:*

(I) *Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or*

(II) *Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);*

B. *Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or*

C. *Direct current electrical bone-growth stimulator is covered for the following indications:*

(I) *Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);*

(II) *Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or*

(III) *Members who are at high risk for spinal fusion failure when any of the following criteria is met:*

(a) *A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);*

(b) *Grade II or worse spondylolisthesis; or*

(c) *One (1) or more failed fusions.]*

41. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered[.]; *[Non-network facility charges and payments for transplants are limited to the following maximums:*

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-

nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);]

44. Urgent care. *[Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care]* **Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan;** and

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: This amendment adds limitations for the following medical benefits, services, or supplies: genetic counseling, non-provider allergy services, or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning, non-covered drugs, non-reusable disposable supplies, and routine foot care without the presence of systemic disease that affects lower extremities. These items were previously contained in 22 CSR 10-2.055. In addition, this amendment clarifies limitations

regarding experimental/investigational/unproven services, procedures, supplies, or drugs; athletic services; physical fitness; and therapy for improvement of athletic performance. Non-medically necessary services was moved to subsection (1)(NN) and services obtained at a government facility if care is provided without charge was moved to subsection (1)(WW) to correct the alphabetical order of the subsections in section (1).

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055.

(F) Athletic *[training]* **enhancement services and sports performance training.**

(V) *[Experimental or investigational]* **Experimental/investigational/unproven** services, procedures, supplies, or drugs as determined by the claims administrator.

[(X) Services obtained at a government facility if care is provided without charge.]

[(Y)](X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

(Y) **Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.**

(MM) **Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advanced by the PBM.**

(NN) **Non-medically necessary services.**

(OO) **Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.**

(PP) **Non-reusable disposable supplies.**

[(MM)](QQ) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

[(NN)](RR) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

[(OO)](SS) Physical and recreational fitness.

[(PP)](TT) Private-duty nursing.

(UU) **Routine foot care without the presence of systemic disease that affects lower extremities.**

[(QQ)](VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.

[(RR) Services not medically necessary.]

(WW) **Services obtained at a government facility if care is provided without charge.**

[(SS)](XX) Sex therapy.

[(TT)](YY) Surrogacy—pregnancy coverage is limited to plan member.

[(UU)](ZZ) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(VV)](AAA) Therapy. Physical, occupation, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in

function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance *[or for recreation];*

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

[(WW)](BBB) Travel expenses.

[(XX)](CCC) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500)

in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the order of benefit determination rules.

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan's [has] rules [coordinating its benefits with those of MCHCP; and

2. Both those rules] and MCHCP's rules require MCHCP [benefits be determined before those of the other plan] to be primary; or

2. The other plan's rules conflict with MCHCP's rules, then the plan that has been in effect the longest is primary.

AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2014] 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

PURPOSE: This amendment clarifies appeals must be made within one hundred eighty (180) days of issuance of the denial or notice, changes the name Coventry Health Care of Kansas, Inc. to Aetna, updates Aetna appeal address, fax, and telephone contact information, updates the address for Pharmacy Lock-In Program appeals, and removes language regarding appeals of a late submission of a Health Care Provider Form.

(2) General Appeal Provisions for Medical and Non-Medicare Primary Pharmacy Services.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of [receiving] issuance of the denial or notice which gave rise to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR, [Coventry Health Care of Kansas, Inc.] Aetna, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review

process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; **or**

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-13J2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time

allowed to supply it ends, whichever is first.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Coventry Health Care of Kansas, Inc.] Aetna*—

(a) First and second level appeals must be submitted in writing to—

[Coventry Health Care of Kansas, Inc.]
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408]
Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512
or by fax to (859) 425-3379

(b) Expedited appeals must be communicated by calling **[(913) 202-5000] (800) 245-0618** or by submitting a written fax to **[(866) 769-2408] (859) 425-3379, Attention: Appeals Resolution Team.**

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*[Express Scripts Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-

6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; **and**

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; **and**.

[(M) MCHCP may approve appeals of a late submission of a Health Care Provider Form if the subscriber can provide substantiating evidence that the annual wellness exam was received timely, that the subscriber reasonably relied on the health care provider to submit the Health Care Provider Form, and the health care provider failed to submit the Health Care Provider Form prior to the May 31 due date.]

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the 2016 Coverage Gap Stage and Catastrophic Coverage Stage annual costs and coinsurance amounts.

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicare Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach two thousand nine hundred sixty dollars (\$2,960), the member will pay the following copayments:

A. Generic Formulary Drugs: thirty-one- (31-) day supply has an eight dollar (\$8) copayment; sixty- (60-) day supply has a sixteen dollar (\$16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar (\$24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar (\$20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar (\$35) copayment; sixty- (60-) day supply has a seventy dollar (\$70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar (\$105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent (\$87.50) copayment; and

C. Non-preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment./.;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[two thousand nine hundred sixty dollars (\$2,960)]* **three thousand three hundred ten dollars (\$3,310)** and remain below *[four thousand seven hundred dollars (\$4,700)]* **four thousand eight hundred fifty dollars (\$4,850)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[four thousand seven hundred dollars (\$4,700)]* **four thousand eight hundred fifty dollars (\$4,850)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[four thousand seven hundred dollars (\$4,700)]* **four thousand eight hundred fifty dollars (\$4,850)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[two dollar and sixty-five cent (\$2.65)]* **two dollar and ninety-five cent (\$2.95)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a *[six dollar and sixty cent (\$6.60)]* **seven dollar and forty cent (\$7.40)** copayment for

all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (5).

PURPOSE: This amendment removes duplicative language regarding home delivery program copayments and coinsurance amounts, clarifies the specialty drug benefit, updates the term prior authorization to preauthorization, replaces the term physician with provider, and removes unnecessary language regarding step therapy and quantity level limits.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300)

for up to a ninety- (90-) day supply for a drug not on the formulary;
D. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program.

[(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;]

[(d)] A member must choose how maintenance prescriptions will be filled by notifying the [pharmacy benefit manager (PBM)] PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

[I.](a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum; and

[(II).](b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. **All specialty prescriptions must be filled through the PBM's specialty pharmacy.** The first fill of a specialty prescription [order] may be filled through a retail pharmacy **if the prescription is identified by the PBM as emergent; [, except for Hepatitis C specialty drugs and those select drugs that have been included in the specialty split-fill program.**

(a) Generic copayment: Eight dollars (\$8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars (\$35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars (\$100) for a drug not on the formulary;]

[(III)](a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up

to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug which shall not apply to the out-of-pocket maximum; and

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; *[and]*

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—five thousand one hundred dollars (\$5,100);

D. Family—ten thousand two hundred dollars (\$10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery programs.

(I) Maintenance prescriptions may be filled through the

PBM's home delivery program.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.]

[(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.]

[(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.]

[(d)] A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

[(I.)(a)] If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

[(II.)(b)] Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; [and/

(II) Specialty drugs are covered only through [network] the specialty home delivery network for up to a thirty-one- (31-) day[s] supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy. The first fill of a specialty prescription may be filled through a retail pharmacy if the prescription is identified by the PBM as emergent;

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

[(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

[(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;]

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; [and/

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

F. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network

pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the [pharmacy benefit manager] PBM, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other, more costly therapy, if necessary. The member is responsible for paying the full price for the prescription drug unless the member's [physician] provider prescribes a first-step drug. If the member's [physician] provider decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the [physician] provider may request a [prior authorization] preauthorization from the PBM. If the [prior authorization] preauthorization is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested [prior authorization] preauthorization is not approved, then the member is responsible for the full price of the drug.

[(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First-step drugs must be attempted before the plan will authorize payment for second-step drugs.

[(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first-step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.]

(5) Quantity Level Limits. Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. *[Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.]*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions.
The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), (6), and (10), and adding section (14).

PURPOSE: This amendment clarifies the terms and conditions, eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth; employee and dependent effective dates when adding coverage due to a life event, deadline for proof of eligibility documentation, documentation requirements for disabled dependents, documentation required to terminate coverage due to the death of a dependent, requirements for Medicare members, and removes repetitive language regarding addition of dependents.

(1) Terms and Conditions. This rule provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). A foster parent and his/her dependents are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by the foster parent and seek recovery and/or pursue legal action to the extent the foster parent has provided incomplete, false, or inaccurate information. *[Purchase of the insurance is at the foster parent's own expense. MCHCP does not contribute toward the premium. The term "foster parent" means any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.]*

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent after the guardianship ends by operation of law when the child becomes eighteen (18)

years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's day of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber; or

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(C) may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. *[MCHCP]* The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(C) An eligible foster parent may apply for coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent and his/her spouse/child(ren) may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for *[coverage of]*

covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. If an eligible foster parent is enrolled in the **PPO 300 or PPO 600 Plan** and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year; or

6. If an eligible foster parent is enrolled in the **Health Savings Account (HSA) Plan** and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

7. If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

6./8. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(4) Effective Date Provisions. In no circumstances can the effective date be before the eligibility date or before January 1, 2013. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Eligible Foster Parent and Dependent Effective Dates.

1. Unless stated otherwise by these rules, an eligible foster parent and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for **[newborns] coverage being added due to a birth, adoption, or placement of children**, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an eligible foster parent enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility, **unless enrollment is received on the first day of a month, in which case coverage is effective on that day;**

B. Newborn.

(I) If a subscriber or eligible foster parent enrolls *[his/her] an eligible newborn [or a subscriber enrolls a newborn of his/her dependent]* within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) **If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.**

[[/]](III) If a subscriber does not elect to enroll a newborn of a dependent child within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child due to establishment of paternity within thirty-one (31) days of the date paternity is established, coverage

becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or eligible foster parent enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption~~/~~.

(II) **If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;**

E. Legal guardianship and legal custody.

(I) If a subscriber or eligible foster parent enrolls a child due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or eligible foster parent enrolls a foster child due to placement in the subscriber or eligible foster parent's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Eligible Foster Parent.

(I) If an eligible foster parent enrolls due to a life event, the effective date for the eligible foster parent is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) **If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated.**

3. An eligible foster parent who elects coverage and/or changes coverage levels for him/herself and his/her spouse/child(ren) or dependents during open enrollment shall have an effective date of January 1 of the following year.

4. If a foster parent gains state employment, s/he must enroll as a new state employee.

5. Coverage is effective for a dependent the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the *[letter]* date **MCHCP processed the enrollment**, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. **If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.**

[[A] Addition of Dependents. Required documentation

should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the spouse/child(ren) not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation within the above stated time frames will result in the spouse/child(ren) being ineligible for coverage until the next open enrollment period;]

[2.](A) When enrolling a newborn, the member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the member of the steps to initiate coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; and].

[3.](B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Addition of biological child(ren)	Government-issued birth certificate or other government-issued or legally-certified proof of paternity listing subscriber as parent and child's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Order of placement
Adoption of dependent(s)	Order of placement; or Filed petition for adoption listing subscriber as adoptive parent (documentation must be received with the enrollment forms) and final adoption decree or birth certificate issued (documentation must be received within thirty-one (31) days of the date the court enters a final decree of adoption)/.
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers (Power of Attorney is not acceptable)
Addition of a child(ren) of covered dependent	Government-issued birth certificate or legally-certified proof of paternity for the child(ren) listing dependent as parent with child's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of persons covered

/(B)/(C) An eligible foster parent and his/her spouse/child(ren) enrolling due to a loss of employer-sponsored group coverage. The foster parent must submit documentation of proof of loss within sixty (60) days of enrollment. Failure to provide the required documentation within the above stated time frames will result in the foster parent and his/her spouse/child(ren) being ineligible for coverage until the next open enrollment period.

/(C)/(D) The eligible foster parent is required to notify MCHCP on the appropriate form of the spouse/child's name, date of birth, eligibility date, and Social Security number.

/(D)/(E) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted

to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and/. Evidence could be from the Social Security Administration (SSA), representation from the dependent's or child's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and/

[C./B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled [by SSA].

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(E) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.]

(6) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make premium payment for the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber and his/her dependents will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Loss of foster parent licensure as determined by the Department of Social Services;

3. With respect to dependents, upon divorce or legal separation from the subscriber or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her enrolled ex-spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

4. Death of dependent. The dependent's coverage ends on the date of death. *The subscriber must submit a completed form and a copy of the death certificate within thirty-one (31) days of death;*

5. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

6. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

7. A subscriber has obtained access to other health insurance coverage through an employer or spouse's employer; or

8. A member otherwise loses benefit eligibility.

(10) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.]

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

(14) Members are required to annually disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will not be processed until the information is received. Once the information is received, claims will be processed subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. [2014] 2013. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

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**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending the purpose and section (2).

PURPOSE: This amendment clarifies the services available at the Strive for Wellness® Health Center.

PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the [MCHCP] Strive for Wellness® [h]Health [c]Center.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(G) Allergies *[allergy injections (maintenance doses only)]*;

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Amended:

Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.150 Disease Management Services Provisions and Limitations. The Missouri Consolidated Health Care Plan is amending the purpose, sections (1), (2), (3), (4), (7), and (8), adding sections (5) and (6), and renumbering as necessary.

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program **and**, the disease management [incentive, and the diabetes management incentive] rewards; and the method and timeframes in which the requirements of the [incentive] disease management rewards must be completed.

(1) Disease management services include: disease management **and** [and] disease management [incentive, and the diabetes management incentive] rewards. Disease management is administered through Missouri Consolidated Health Care Plan's (MCHCP's) disease management vendor. The disease management [incentive and the diabetes management incentive] rewards are administered through the MCHCP Pharmacy Benefit Manager and medical plans in conjunction with [Missouri Consolidated Health Care Plan's (MCHCP)] MCHCP's disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor, **has completed one (1) one-on-one call with a DM Nurse**, and one (1) of the following occurs:

1. [Is working] **Continues to work** one-on-one with a DM nurse; **or**

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse. [until the DM vendor determines the condition can be managed independently; or]

[3. The DM vendor has determined the member does not require one-on-one work with a DM nurse.]

(3) Disease Management [Incentive] Rewards.

(A) Members actively participating in a DM program through MCHCP's DM vendor are eligible to receive the following respective rewards: [reduced non-formulary prescription copayment

or coinsurance:

1. PPO 300 Plan or PPO 600 Plan members—

A. Fifty-five dollars (\$55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;

B. One hundred ten dollars (\$110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;

C. One hundred sixty-five dollars (\$165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;

D. One hundred thirty-seven dollars and fifty cents (\$137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;

2. HSA Plan members—

A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.

(B) Members actively participating in DM on December 1, 2014 will receive the DM Incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.

(4) Diabetes Management Incentive.

(A) Members with a diagnosis of diabetes confirmed through either claims data or through a provider's certification must complete the following to be eligible to receive the diabetes management incentive:

1. Enroll in the diabetes DM program through MCHCP's DM vendor; and

2. Actively participate in diabetes DM.

(B) Members actively participating in diabetes DM are eligible to receive:

1. Reduced prescription drug copayment or coinsurance for prescriptions directly related to the treatment of diabetes and the listed diabetic supplies at one hundred percent (100%) as specified:]

[A.]1. PPO 300 Plan or PPO 600 Plan members—

[[I]]A. Formulary generic copayment for **Diabetes medications:** Four dollars (\$4) for up to a thirty-one- (31-) day supply; eight dollars (\$8) for up to a sixty- (60-) day supply; twelve dollars (\$12) for up to a ninety- (90-) day supply through a network retail pharmacy or ten dollars (\$10) for up to a ninety- (90-) day supply through home delivery./;]

[[II]]B. Formulary brand copayment for **Diabetes medications:** Seventeen dollars and fifty cents (\$17.50) for up to a thirty-one- (31-) day supply; thirty-five dollars (\$35) for up to a sixty- (60-) day supply; fifty-two dollars and fifty cents (\$52.50) for up to a ninety- (90-) day supply through a network retail pharmacy or forty-three dollars and seventy-five cents (\$43.75) for up to a ninety- (90-) day supply through home delivery./;]

[[III]]C. Non-formulary brand copayment for **all medications:** fifty dollars (\$50) for up to a thirty-one- (31-) day supply; one hundred dollars (\$100) for up to a sixty- (60-) day supply; one hundred fifty dollars (\$150) for up to a ninety- (90-) day supply through a network retail pharmacy or one hundred twenty-five dollars (\$125) for up to a ninety- (90-) day supply through home delivery./;]

[[IV]]D. Formulary [G]glucometer received at a network pharmacy covered at one hundred percent (100%), one (1) per plan year./;]

[[V]]E. Prescribed [F]formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%)./; and

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%);

[B.]2. HSA Plan members—

[[I]]A. Formulary generic coinsurance for **Diabetes medications:** Five percent (5%) after deductible;

[[II]]B. Formulary brand coinsurance for **Diabetes medications:** Ten percent (10%) after deductible;

[[III]]C. Non-formulary brand coinsurance for all medications: twenty percent (20%) after deductible;

[[IV]]D. Formulary [G]glucometer, received at a network pharmacy covered at one hundred percent (100%) after deductible, one (1) per plan year[.];

[[V]]E. Prescribed [F]formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%) after deductible[.]; and

[2.]F. [Three (3)] Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%) [for PPO Plan members or at one hundred percent (100%)] after deductible [is met for HSA Plan members].

[[5]](4) [The incentives will start no later than thirty (30) days after active participation begins.] DM Rewards shall begin January 1, 2016 and end December 31, 2016.

(5) Eligible members who are participating in a DM program through MCHCP's DM vendor on December 1, 2015 shall begin receiving DM Rewards on January 1, 2016.

(6) Eligible members who are participating in a DM program through MCHCP's DM vendor after December 1, 2015 shall begin receiving DM Rewards the first day of the second month after the eligible member has completed one (1) one-on-one call with a DM nurse.

[[6]](7) Eligible members failing to actively participate in DM will lose the [disease management incentive or the diabetes management incentive] DM Rewards [and will become ineligible for the respective incentive(s)] for the remainder of the year effective the first day of the second month after MCHCP learns the eligible member has stopped participating.

[[7]](8) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of the [disease management incentive and the diabetes management incentive,] DM Rewards and/or prosecution.

[[8]](9) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.160 Pharmacy Lock-In Program. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies the definition of lock-in, the process for once the PBM determines a member has misutilized pharmacy benefits, eligibility of prescription coverage, and the pharmacy change request address.

(2) Definitions. The following definitions apply to this program:

(B) Lock-in: The method to limit or restrict a member to *[a designated] one (1) network pharmacy designated* for the filling of specified prescription medication(s); and

(4) Once the PBM determines a member has misutilized pharmacy benefits, the PBM will *[notify the member, and]* refer the member to MCHCP's vendor for case management *and[. The notification process includes:*

(A) The PBM] will send a letter [requesting] notifying the member [to select one (1) designated] of their locked-in status. The letter will include the network pharmacy location[,] designated to fill the specified prescription medication(s)[, from three (3) pharmacy locations identified by the PBM based on the member's demographic area and past prescription fill history;

(B) The member must notify the PBM of his/her pharmacy selection no later than three (3) weeks from the date of the letter;

(C) If the member fails to make a selection, the PBM will choose a pharmacy for the member; and

(D) The PBM will send the member a letter confirming the designated pharmacy and effective date for the lock-in program.]

(5) Once locked-in to a designated network pharmacy, prescriptions for controlled substances and muscle relaxants will only be covered if filled at the designated pharmacy and otherwise eligible for *[payment] coverage.*

(7) Pharmacy change requests requirements—

(B) Must be submitted in writing to:

*[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

; and

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (31), (56), (57), and (58).

PURPOSE: This amendment revises the definitions of experimental/investigational/unproven, primary care physician, prior authorization, and provider.

(31) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

[(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or]

[(C)](B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis/.; or

[(D)](C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(56) Primary care *[physician] provider* (PCP). An internist, family/general practitioner, *for/* pediatrician, or **physician assistant or nurse practitioner in any of the practice areas listed in this definition.**

(57) *[Prior authorization] Preauthorization.* A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called *[pre-authorization] prior authorization*, prior approval, or precertification. The plan may require *[prior authorization] preauthorization* for certain services before the member receives them, except in an emergency. *[Prior authorization] Preauthorization* is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request *[prior authorization] preauthorization*.

(58) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(21). Other providers include, but are not limited to:

(F) Licensed Clinical Social Worker (LCSW);

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For inter-

vening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (12).

PURPOSE: This amendment clarifies eligibility requirements for a newborn of a dependent or child of a dependent when paternity by the dependent is established after birth, employee and dependent effective dates when adding coverage due to a life event, documentation requirements for disabled dependents, and moves notification requirements for Medicare eligible members from the proof of eligibility section to the Medicare section.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree.

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the

foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent or child of a dependent when paternity by the dependent is established after birth so long as the parent **is a dependent on the newborn's day of birth or the date the child's paternity was established and** continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependents or an employee rehired after his/her coverage terminates and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date, as determined by the employer. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date and after the waiting period. Except for *[newborns]* coverage being added due to a birth, adoption, or placement of child(ren), the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as fol-

lows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

B. Newborn.

(I) If a subscriber or employee enrolls *[his/her]* an eligible newborn *[or a subscriber enrolls a newborn of his/her dependent]* within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber or employee enrolls an eligible spouse and/or child(ren) within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.

[[/]](III) If a subscriber does not elect to enroll a newborn of a dependent child within thirty-one (31) days of birth, s/he cannot enroll the newborn of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption, or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Employee.

(I) If an employee enrolls due to a life event or loss of employer-sponsored coverage, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated;

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and [Evidence could be from the Social Security Administration, representation from the dependent's or child's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's or child's physician describing the current disability and verifying that the disability predates the dependent's or child's twenty-sixth birthday and the disability is permanent; and]

[C./B. A benefit verification letter dated within the last twelve (12) months from the [Social Security Administration (SSA)] confirming the child is still considered disabled [by SSA].

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

[(G) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.]

(12) Medicare.

[(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.]

[(C)](B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(C) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment updates the term "prior authorization" to "preauthorization" and clarifies the requirements for preauthorization of physical, speech, and occupational therapy and rehabilitation services.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) [Prior Authorization] **Preauthorization** of Services—The claims administrator must authorize some services in advance. Without [prior authorization] **preauthorization**, any claim that requires [prior authorization] **preauthorization** will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to [prior authorization] **preauthorization** under this rule. [Prior authorization] **Preauthorization** does not verify eligibility or payment. [Prior authorizations] **Preauthorizations** found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to [prior authorization] **preauthorization**:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care;

K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

L. Genetic testing or counseling;

M. Hearing Aids;

N. Home health care;

O. Hospice care and palliative services;

P. Hospital inpatient services;

Q. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

R. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

S. Nutritional counseling after six (6) sessions annually;

T. Orthognathic surgery;

U. Orthotics over one thousand dollars (\$1,000);

V. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per *[incident]/ calendar year*;

W. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

X. Prostheses over one thousand dollars (\$1,000);

Y. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

Z. Skilled nursing facility;

AA. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

BB. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to *[prior authorization]* **preauthorization**:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; **and**

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy; *and*].

3. *[Prior authorization]* **Preauthorization** timeframes.

A. A benefit determination for non-urgent *[prior authorization]* **preauthorization** requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit

necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent *[prior authorization]* **preauthorization** requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision; *and*

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation, coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review; *and*

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; *and*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED RESCISSION

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 1000 Plan benefit provisions and charges.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016,

expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.

PUBLIC COST: *This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.*

(1) Deductible—per calendar year for network: per individual, one thousand dollars (\$1,000); family, three thousand dollars (\$3,000) and for non-network: per individual, two thousand dollars (\$2,000); family, six thousand dollars (\$6,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000) and for non-network: per individual, ten thousand dollars (\$10,000); family, thirty thousand dollars

(\$30,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Each subscriber will have access to payment information of the family unit.

(8) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

(9) Copayments. Copayments apply to network services unless otherwise specified:

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to

emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(10) Usual, customary, and reasonable fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(11) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(12) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(13) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RESCISSION

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan

Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify Health Savings Account Plan benefit provisions and charges.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2014] 2013. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, and expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, four thousand dollars (\$4,000); family, eight thousand dollars (\$8,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance—Coinsurance amounts apply to covered services

after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—three thousand three hundred dollars (\$3,300).

2. Network out-of-pocket maximum for family—six thousand six hundred dollars (\$6,600).

3. Non-network out-of-pocket maximum for individual—five thousand dollars (\$5,000).

4. Non-network out-of-pocket maximum for family—ten thousand dollars (\$10,000).

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutritional counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Newborn's claims will be subject to deductible and coinsurance.

(9) Each subscriber will have access to payment information of the family unit.

(10) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan

year.

(11) Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (15) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

(15) A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

(16) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or

political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RESCISSION

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify PPO 600 Plan benefit provisions and charges.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Rescinded: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, six hundred dollars (\$600); family, one thousand two hundred dollars (\$1,200) and for non-network: per individual, one thousand two hun-

dred dollars (\$1,200); family, two thousand four hundred dollars (\$2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000) and for non-network: per individual, three thousand dollars (\$3,000); family, six thousand dollars (\$6,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such

adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

- (A) Preventive care;
- (B) Nutritional counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth.

(6) Influenza immunizations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Each subscriber will have access to all payment information of the family unit.

(8) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans during the plan year or continues enrollment under another subscriber's plan within the same plan year.

(9) Copayments—Copayments apply to network services unless otherwise specified.

(A) Emergency room—one hundred dollars (\$100) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(10) Usual, customary, and reasonable limit fee allowed—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

(11) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(12) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(13) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expires

June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3); and renumbering as necessary.

PURPOSE: This amendment clarifies the following benefits: allergy testing and immunotherapy, bariatric surgery, contraception and sterilization, durable medical equipment, foot care, genetic counseling, genetic testing, hospice, hospital, preventive services, transplants, and urgent care; corrects the alphabetical order of benefits by moving Bone Growth Stimulators to paragraph (3)(E)4.; and adds coverage of blood pressure cuffs/monitors with a diagnosis of diabetes.

(3) Covered Charges Applicable to the PPO 600 Plan, PPO 1000, and HSA Plan.

(E) Plan benefits for the PPO 600 Plan, PPO 1000, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. *[No coverage for no provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]* Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or

- (II) Inhalants;
- D. Skin Patch Testing: for diagnosing contact allergic dermatitis;
- E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);
- F. Photo Tests: for evaluating photo-sensitivity disorders;
- G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:
 - (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
 - (II) Skin testing is unreliable;
- H. Exercise Challenge Testing for exercise-induced bronchospasm;
- I. Ingestion (Oral) Challenge Test for any of the following:
 - (I) Food or other substances; or
 - (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;
- J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:
 - (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
 - (II) Food allergy;
 - (III) Hymenoptera venom allergy (stinging insects);
 - (IV) Inhalant allergy; or
 - (V) Specific drugs;
- K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;
- L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:
 - (I) Sensitivity to beryllium;
 - (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
 - (III) Thymoma; and
 - (IV) To predict allograft compatibility in the transplant setting;
- M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;
- N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:
 - (I) Allergic (extrinsic) asthma;
 - (II) Dust mite atopic dermatitis;
 - (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
 - (IV) Mold-induced allergic rhinitis;
 - (V) Perennial rhinitis;
 - (VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:
 - (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
 - (b) Member has a life-threatening allergy to insect stings; or
 - (c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and
 - (VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;
- O. Other treatments: the following other treatments are covered:
 - (I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:
 - (a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;
 - (b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
 - (c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;
 - (II) Rapid desensitization is considered experimental and investigational for other indications;
 - P. Epinephrine kits[, *Ana-Kit*, and *Epi-Pen kits*] to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;
- 2. Ambulance service. The following ambulance transport services are covered:
 - A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;
 - B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;
- 3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years;
- 4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:
 - A. The surgery is performed at a facility accredited by **the [one (1) of the following accreditation programs:]**
 - [(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);*
 - [(II) American Society for Metabolic and Bariatric Surgery Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or*
 - [(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;*
 - B. The following open or laparoscopic bariatric surgery procedures are covered:
 - (I) Roux-en-Y gastric bypass;
 - (II) Sleeve gastrectomy;
 - (III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);
 - (IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;
 - (V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;
 - (VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:
 - (a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or
 - (b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;
 - C. All of the following criteria have been met:
 - (I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:
 - (a) BMI greater than forty (40); or
 - (b) BMI between thirty-five (35) and thirty-nine and

nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;
 II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.); or

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

/5./6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women

with reproductive capacity;/. *The following contraceptive devices and injections are covered when administered in a provider's office:*

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(III) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;]

/6./7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

/7./8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

/8./9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

/9./10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that maybe relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

- (II) The symptoms being treated;
- (III) Diagnostic procedures and results;
- (IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

[10.]11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

[11.]12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered

when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

[12.]/13. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury;

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

[13.]/14. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

[14.]/15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

[F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;]

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[15.]/16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit.

Hospital and ancillary charges are paid as a network benefit;

[16.]/17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

[17.]/18. Foot care (trimming of nails, corns, or calluses). *[Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities.]* Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[18.]/19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals *[from ethnic groups]* recognized to be at increased risk for *[specific]* genetic disorders *[e.g., African Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease];*

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with *[mental retardation]* **intellectual developmental disorders**, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[19.]20. Genetic testing. *[No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA).]*

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

[A.](I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

[B.](II) The result of the test will directly impact the treatment being delivered to the member;

[C.](III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

[D.](IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;/.]

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[20.]21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[21.]22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[22.]23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A comprehensive medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[23.]24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[24.]25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by, or under the supervision of, a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by, or under the supervision of, a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[25.]26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by, or under the supervision of, a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within *[six (6) months] twelve (12) months* of death;

[26.]27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services *[not otherwise offered in an outpatient setting]* **provided on less than a full-time inpatient basis.** *[The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week.]* The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; **and**

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility, and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; *and/*

[(VI) Inpatient treatment in a network hospital or facility by a non-network provider. Inpatient treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;]

[27.]28. Injections and infusions. Injections and infusions are

covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

[28.]29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[29.]30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[30.]31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[31.]32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein

to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[32./33. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[33./34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[34./35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequelae;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviations from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[35./36. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering, or expected to interfere, significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

- (IV) Edema of lower extremities;
- (V) Edema during pregnancy; or
- (VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

- (I) Orthopedic footwear;
- (II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;
- (c) Calcaneal bursitis (acute or chronic);
- (d) Calcaneal spurs (heel spurs);
- (e) Conditions related to diabetes;
- (f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);
- (g) Medial osteoarthritis of the knee;
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or

related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[36./37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. *[Annual physical]* **Preventive** exams and routine lab and X-ray services ordered as part of the *[annual]* exam. *[One (1) exam per calendar year is covered. Additional visits as needed to*

obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.] For benefits to be covered as preventive, including X-rays and lab services, they must be coded by [your physician] the provider as routine, without indication of an injury or illness.

F. Cancer screenings. **One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—**

(I) Mammograms—[one (1) exam per year,] no age limit;

(II) Pap smears—[one (1) per year,] no age limit;

(III) Prostate—[one (1) per year,] no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema. [per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.]

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

[37.]38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[38.]39. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2 max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[39.]40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[40. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate

healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;]

41. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parent(s). The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. *[Non-network facility charges and payments for transplants are limited to the following maximums:]*

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);]

44. Urgent care. *[Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care] Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and*

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1) and renumbering as necessary.

PURPOSE: This amendment adds limitations for the following medical benefits, services, or supplies: genetic counseling, non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning, non-covered drugs, non-reusable disposable supplies, and routine foot care without the presence of systemic disease that affects lower extremities. These items were previously contained in 22 CSR 10-3.057. In addition, this amendment clarifies limitations regarding experimental/investigational/unproven services, procedures, supplies, or drugs; athletic services; physical fitness; and therapy for improvement of athletic performance. Non-medically necessary services was moved to subsection (1)(NN) and services obtained at a government facility if care is provided without charge was moved to subsection (1)(WW) to correct the alphabetical order of the subsections in section (1).

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise, and then only to the extent expressly provided herein or in 22 CSR 10-3.057.

(F) Athletic *[training]* enhancement services and sports performance training.

(V) *[Experimental or investigational]* Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

[(X) Services obtained at a government facility if care is provided without charge.]

[(Y)](X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

(Y) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(MM) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advanced by the PBM.

(NN) Non-medically necessary services.

(OO) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(PP) Non-reusable disposable supplies.

[(MM)](QQ) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;
2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;
3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and
4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

[(NN)](RR) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

[(OO)](SS) Physical and recreational fitness.

[(PP)](TT) Private-duty nursing.

(UU) Routine foot care without the presence of systemic disease that affects lower extremities.

[(QQ)](VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.

[(RR) Services not medically necessary.]

(WW) Services obtained at a government facility if care is provided without charge.

[(SS)](XX) Sex therapy.

[(TT)](YY) Surrogacy—pregnancy coverage is limited to plan member.

[(UU)](ZZ) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

[(VV)](AAA) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—
 - A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;
 - B. Treatment intended to improve or maintain general physical condition;
 - C. Long-term rehabilitative services when significant therapeutic improvement is not expected;
 - D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);
 - E. Work hardening programs;
 - F. Back school;
 - G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;
 - H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or
 - I. Services for the purpose of enhancing athletic or sports performance *[or for recreation]*;
2. Occupational therapy—
 - A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;
 - B. Treatment intended to improve or maintain general physical condition;
 - C. Long-term rehabilitative services when significant therapeutic improvement is not expected;
 - D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);
 - E. Work hardening programs;
 - F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;
 - G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);
 - H. Driving safety/driver training; and
3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

[(WW)](BBB) Travel expenses.

[(XX)](CCC) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the order of benefit determination rules.

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan's *[has]* rules *[coordinating its benefits with those of MCHCP; and*

2. *Both those rules]* and MCHCP's rules require MCHCP *[benefits be determined before those of the other plan.] to be*

primary; or

2. The other plan's rules conflict with MCHCP's rules, then the plan that has been in effect the longest is primary.

AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2014] 2013. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

PURPOSE: This amendment clarifies appeals must be made within one hundred eighty (180) days of issuance of the denial or notice, updates the address for Pharmacy Lock-In Program appeals, and removes references to Coventry Health Care of Kansas, Inc.

(2) General Appeal Provisions.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of [receiving] issuance of the denial or notice which gave rise to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not

medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR[, Coventry Health Care of Kansas, Inc.,] and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review; and

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect, except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; or

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review, except as specifically provided in 22 CSR 10-3/2/.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's

medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor's control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

[(VI) For members with medical coverage through Coventry Health Care of Kansas, Inc. —

(a) First and second level appeals must be submitted in writing to—

*Coventry Health Care of Kansas, Inc.
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408*

(b) Expedited appeals must be communicated by calling (913) 202-5000 or by submitting a written fax to (866) 769-2408.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

*[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

(IV) Pharmacy appeals will be reviewed by someone who

was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (6).

PURPOSE: This amendment removes duplicative language regarding home delivery program copayments and coinsurance amounts, clarifies the specialty drug benefit, updates the term prior authorization to preauthorization, replaces the term physician with provider, and removes unnecessary language regarding step therapy and quantity level limits.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Home delivery programs—

(I) Maintenance prescriptions may be filled through the **pharmacy benefit manager's (PBM's)** home delivery program.

[(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary.

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d)] A member must choose how maintenance prescription(s) will be filled by notifying the [pharmacy benefit manager (PBM)] of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

[(e)](a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

[(f)](b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. **All specialty prescriptions must be filled through the PBM's specialty pharmacy.** The first fill of a specialty prescription *[order]* may be filled through a retail pharmacy **if the prescription is identified by the PBM as emergent;/, except for Hepatitis C specialty drugs and those select drugs that have been included in the specialty split-fill program.**

(a) *Generic copayments: Eight dollars (\$8) for a generic drug on the formulary list.*

(b) *Brand copayments: Thirty-five dollars (\$35) for a brand drug on the formulary.*

(c) *Non-formulary copayments: One hundred dollars (\$100) for a drug not on the formulary;]*

[(III)](a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, and up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) **Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;**

(b) **Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;**

(c) **Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.**

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug which shall not apply to the out-of-pocket maximum.

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (cate-

gories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars (\$5,100).

D. Family—ten thousand two hundred dollars (\$10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d)] A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

[(e)](a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

[(f)](b) Once a member makes his/her delivery decision,

the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to thirty-one (31) days.

[(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.]

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

F. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the *[pharmacy benefit manager] PBM*, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. The member is responsible for paying the full price for the prescription drug unless the member's *[physician] provider* prescribes a first-step drug. If the member's *[physician] provider* decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first-step drug, the *[physician] provider* may request a *[prior authorization] preauthorization* from the PBM. If the *[prior authorization] preauthorization* is approved, the member is responsible for the applicable copayment, which may be higher than the first-step drug. If the requested *[prior authorization] preauthorization* is not approved, then the member is responsible for the full price of the drug.

[(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First-step drugs must be attempted before the plan will authorize payment for second-step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first-step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.]

(6) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. *[Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.]*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.150 Disease Management Services Provisions and Limitations. The Missouri Consolidated Health Care Plan is amending the purpose, sections (1), (2), (3), (4), (7), and (8), adding sections (5) and (6), and renumbering as necessary.

PURPOSE: This amendment changes the disease management and diabetes management incentives to Disease Management Rewards and clarifies participation requirements, benefits, and copayments and coinsurance amounts.

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program and[,] the disease management [incentive, and the diabetes management incentive] rewards; and the method and timeframes in which the requirements of the [incentive] disease management rewards must be completed.

(1) Disease management services include: disease management and[,] disease management [incentive, and the diabetes management incentive] rewards. Disease management is administered through Missouri Consolidated Health Care Plan's (MCHCP's) disease management vendor. The disease management [incentive and the

diabetes management incentive] rewards are administered through the MCHCP Pharmacy Benefit Manager and medical plans in conjunction with *[Missouri Consolidated Health Care Plan's (MCHCP's)]* disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor, has completed one (1) one-on-one call with a DM nurse and one (1) of the following occurs:

1. *[Is working]* Continues to work one-on-one with a DM nurse;
2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse *[until the DM vendor determines the condition can be managed independently; or*
3. *The DM vendor has determined the member does not require one-on-one work with a DM nurse].*

(3) Disease Management *[Incentive]* Rewards.

(A) Members actively participating in a DM program through MCHCP's DM vendor are eligible to receive the following respective rewards *[reduced non-formulary prescription copayment or coinsurance]*:

1. PPO 600 Plan or PPO 1000 Plan members—

- A. Fifty-five dollars (\$55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;
- B. One hundred ten dollars (\$110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;
- C. One hundred sixty-five dollars (\$165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;
- D. One hundred thirty-seven dollars and fifty cents (\$137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;

2. HSA Plan members—

- A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.

(B) Members actively participating in DM on December 1, 2014 will receive the DM incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.]

1. PPO 600 Plan or PPO 1000 Plan members—

- A. Formulary generic copayment for diabetes medications: four dollars (\$4) for up to a thirty-one- (31-) day supply; eight dollars (\$8) for up to a sixty- (60-) day supply; twelve dollars (\$12) for up to a ninety- (90-) day supply through a network retail pharmacy or ten dollars (\$10) for up to a ninety- (90-) day supply through home delivery;

B. Formulary brand copayment for diabetes medications: seventeen dollars and fifty cents (\$17.50) for up to a thirty-one- (31-) day supply; thirty-five dollars (\$35) for up to a sixty- (60-) day supply; fifty-two dollars and fifty cents (\$52.50) for up to a ninety- (90-) day supply through a network retail pharmacy or forty-three dollars and seventy-five cents (\$43.75) for up to a ninety- (90-) day supply through home delivery;

C. Non-formulary brand copayment for all medications: fifty dollars (\$50) for up to a thirty-one- (31-) day supply; one hundred dollars (\$100) for up to a sixty- (60-) day supply; one hundred fifty dollars (\$150) for up to a ninety- (90-) day supply through a network retail pharmacy or one hundred twenty-five dollars (\$125) for up to a ninety- (90-) day supply through home delivery;

D. Formulary glucometer received at a network pharmacy covered at one hundred percent (100%), one (1) per plan year;

E. Prescribed formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%);

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%).

2. HSA Plan members—

A. Formulary generic coinsurance for diabetes medications: five percent (5%) after deductible;

B. Formulary brand coinsurance for diabetes medications: ten percent (10%) after deductible;

C. Non-formulary brand coinsurance for all medications: twenty percent (20%) after deductible;

D. Formulary glucometer, received at a network pharmacy covered at one hundred percent (100%) after deductible, one (1) per plan year;

E. Prescribed formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%) after deductible;

F. Four (4) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred percent (100%) after deductible.

(4) *[The incentives will start no later than thirty (30) days after active participation begins.]* DM Rewards shall begin January 1, 2016 and end December 31, 2016.

(5) Eligible members who are participating in a DM program through MCHCP's DM vendor on December 1, 2015 shall begin receiving DM Rewards on January 1, 2016.

(6) Eligible members who are participating in a DM program through MCHCP's DM vendor after December 1, 2015 shall begin receiving DM Rewards the first day of the second month after the eligible member has completed one (1) one-on-one call with a DM nurse.

[(5)](7) Eligible members failing to actively participate in DM will lose *[the disease management incentive or the diabetes management incentive and will become ineligible for the respective incentive(s)]* DM Rewards for the remainder of the year effective the first day of the second month after MCHCP learns the eligible member has stopped participating.

[(6)](8) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of *[the disease management incentive and the diabetes management incentive]* DM Rewards, and/or prosecution.

[(7)](9) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.160 Pharmacy Lock-In Program. The Missouri Consolidated Health Care Plan is amending sections (2), (4), (5), and (7).

PURPOSE: This amendment clarifies the definition of lock-in, the process for once the PBM determines a member has misutilized pharmacy benefits, eligibility of prescription coverage, and the pharmacy request address.

(2) Definitions. The following definitions apply to this program:

(B) Lock-in: The method to limit or restrict a member to *[a designated]* **one (1) network pharmacy designated** for the filling of specified prescription medication(s); and

(4) Once the PBM determines a member has misutilized pharmacy benefits, the PBM will *[notify the member and]* refer the member to MCHCP's vendor for case management. *[The notification process includes:]*

[(A) The PBM] will send a letter [requesting] notifying the member [to select one (1) designated] of their locked-in status. The letter will include the network pharmacy location designated to fill the specified prescription medication(s). [from three (3) pharmacy locations identified by the PBM based on the member's demographic area and past prescription fill history;

(B) The member must notify the PBM of his/her pharmacy selection no later than three (3) weeks from the date of the letter;

(C) If the member fails to make a selection, the PBM will choose a pharmacy for the member; and

(D) The PBM will send the member a letter confirming the designated pharmacy and effective date for the lock-in program.]

(5) Once locked-in to a designated network pharmacy, prescriptions for controlled substances and muscle relaxants will only be covered if filled at the designated pharmacy and otherwise eligible for *[payment]* coverage.

(7) Pharmacy change request requirements—

(B) Must be submitted in writing to:

*[Express Scripts
Drug Utilization Review Program
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603]
Express Scripts
Drug Utilization Review Program
Mail Stop HQ3W03
One Express Way
St. Louis, MO 63121*

; and

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expires June 28, 2016. Amended: Filed Oct. 28, 2015.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 100—Missouri Agricultural and Small Business
Development Authority
Chapter 2—Beginning Farmer Loan Program**

ORDER OF RULEMAKING

By the authority vested in the Missouri Agricultural and Small Business Development Authority under section 348.075, RSMo 2000, the authority amends a rule as follows:

2 CSR 100-2.020 Applicant Eligibility Requirements is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 1, 2015 (40 MoReg 1089). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 100—Missouri Agricultural and Small Business
Development Authority
Chapter 2—Beginning Farmer Loan Program**

ORDER OF RULEMAKING

By the authority vested in the Missouri Agricultural and Small Business Development Authority under section 348.075, RSMo 2000, the authority amends a rule as follows:

2 CSR 100-2.040 Fees is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 1, 2015 (40 MoReg 1089–1090). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 4—DEPARTMENT OF ECONOMIC
DEVELOPMENT
Division 85—Division of Business and Community
Services
Chapter 11—Innovation Campus Tax Credits**

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Economic Development under section 620.2600(6), RSMo Supp. 2014, the director adopts a rule as follows:

4 CSR 85-11.010 Definitions is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 15, 2015 (40 MoReg 871). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 4—DEPARTMENT OF ECONOMIC
DEVELOPMENT
Division 85—Division of Business and Community
Services
Chapter 11—Innovation Campus Tax Credits**

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Economic Development under section 620.2600(6), RSMo Supp. 2014, the director adopts a rule as follows:

4 CSR 85-11.020 Valuations of Donations is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 15, 2015 (40 MoReg 871–872). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
Division 30—Division of Financial and
Administrative Services
Chapter 640—School Buildings**

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under section

161.092, RSMo Supp. 2014, and section 161.215, RSMo Supp. 2013, the board adopts a rule as follows:

5 CSR 30-640.200 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2015 (40 MoReg 834-837). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received eleven (11) comments on the proposed rule.

COMMENT #1: Renee Sagaser and Pat O'Neal, Fair Play R-II School District, indicated the rule would have a negative fiscal impact on their Exceptional Pupil Cooperative of the Ozarks program which serves children from fifteen (15) districts, because the formula was less than their lease cost, and to use a facility within the lease formula would add extra cost to the program in transportation of students and the need for additional staff to fill positions currently shared with programs in buildings adjoining the Early Childhood Special Education (ECSE) program.

RESPONSE AND EXPLANATION OF CHANGE: A new section (7) has been added to the rule which allows cooperative programs to request a waiver if they can demonstrate that complying with the lease formula will increase the total cost of the ECSE program.

COMMENT #2: Andrew Underwood, Belton School District, supports the rule and noted that without limits on lease costs, all districts should start leasing facilities with a high lease payment since the department would pay the cost. Steve Hoots supports capping the lease rates to ensure fiscal accountability. Reverend Virgil K. Hill supports the rule and believes that districts which cannot find a facility within the lease rate are not serving the public good. Thomas Gargus supports the rule to avoid paying for facilities in excess of the fair market rental value of the facility.

RESPONSE: The department agrees with the comments in support of the need for a lease formula.

COMMENT #3: Dave Wilson, Columbia Public Schools, and Dana Carroll, Springfield's Child Advocate, supported the need for fiscal responsibility but indicated that the lease formula was inadequate to cover the cost of leasing property in Columbia and Springfield. Mr. Wilson suggested adjusting the reimbursement rate per square foot or adding an adjustment for cities over a certain population size.

RESPONSE: The department declines to make a change in response to the comment. The data shows that the current lease rate for Boone County was based almost exclusively on leases within the city of Columbia. The rate for Greene County was based only on leases within the city of Springfield.

COMMENT #4: Dave Wilson, Columbia Public Schools, requested that administrative staff be included in the itinerant staff calculation per square footage.

RESPONSE AND EXPLANATION OF CHANGE: The formula and subsections (1)(C) and (4)(C) have been amended to add in a line for administrative staff to allow one hundred twenty (120) square feet for administrative full-time equivalent employee approved in the Final Expenditure Report who is actually housed in the leased facility.

COMMENT #5: Phyllis Wolfram, Springfield R-XII School District, requested that assessment staff and assessment teams be included when determining allowable square footage.

RESPONSE: Assessment staff and assessment teams are included in the formula under subsection (1)(B) as a part of the itinerant full-time equivalent as defined in subsection (4)(F).

COMMENT #6: Nixa Public Schools, represented by Lowell

Pearson, opposes the rule asserting it violates the contract clauses in the *United States and Missouri Constitutions*, the *Hancock Amendment*, and the decision in *Rolla 31 School District v. State of Missouri*. In addition, they state that the fiscal note is not accurate and the rule is inconsistent with public policy. The comments provide detail about how the Nixa Public Schools arrived at a lease rate and maintain that Nixa Public Schools determined the rate based on a lack of objection from the department when they inquired about leasing.

RESPONSE: The Department disagrees. The *Rolla 31 School District* decision requires the state to pay for the cost of ECSE programs. The state pays for the program using general revenue (i.e., taxpayer) dollars. Public policy compels the department to be a good steward of those funds. In the past, the lease expenses, while increasing, were not excessive. When the department received a request from Nixa Public Schools to pay a lease of eight hundred seventy-five thousand dollars (\$875,000) per year for a program that served only one-hundred sixteen (116) children (a cost of seven thousand five hundred forty-three dollars and ten cents (\$7543.10) per child and thirty-five dollars (\$35) per square foot) it became apparent that change was needed to control the excessive costs of the program. Previously, it has been the department's procedure to pay the actual cost of leases negotiated by the district. When presented with an unusually high lease, the department determined that it was necessary to place reasonable and cost-efficient restrictions on a bill the state was required to pay. There is no justification for the state to pay for a lease substantially outside the fair market value, nor to fund a lease with extra space beyond that needed for the number of students served. Protecting taxpayer dollars is a significant and legitimate public purpose which supports the regulation and does not violate the contract clauses.

The *Rolla 31 School District* case requires the state to pay for the full cost of the program. This regulation identifies one (1) part of the full cost of the program. Excessive lease costs are not necessary to conduct an early childhood program. Local districts should not be permitted to disregard prudent purchasing practices when the funding is required to come from the state. The regulation is good public policy.

The regulation does not impair the existing Nixa Public Schools lease, as a limit on lease cost is contemplated in the lease. The lease states "landlord agrees that in the event that these applicable federal, state or local laws or regulations change ...which restrict, reduce or eliminate the state or federal ECSE program funding which pays for the rental payment for the Leased Premises, the tenant shall have the right to terminate the Lease at any time..."

The regulation does not require shifting of payment for ECSE to the local district as prohibited by the *Hancock Amendment*, nor does it prohibit the local district from supplementing the ECSE program.

COMMENT #7: Based on testimony at the hearing before the Joint Committee on Administrative Rules, staff proposed delaying the implementation date of the rule for leases that were in effect on the date the formula was first published in the *Missouri Register*.

RESPONSE AND EXPLANATION OF CHANGE: Section (5) has been amended to delay application of the formula to July 1, 2019 for facilities with signed leases in effect on March 2, 2015.

5 CSR 30-640.200 Early Learning Facilities Funding Formula for Lease Agreements

(1) The department uses the following formula to determine the maximum allowable cost per fiscal year for early learning programs facility lease agreements:

(A) Standard amount of square footage per child multiplied by the total number of eligible pupils educated at the facility multiplied by the cost per square foot by county;

(B) Standard amount of square footage per itinerant full-time equivalent (FTE) position multiplied by the total itinerant FTE multiplied by the cost per square foot by county; and

(C) Standard amount of square footage per administrative FTE position multiplied by the total administrative FTE actually housed in

the leased facility multiplied by the cost per square foot by county.

(4) For purposes of this rule, the following terms mean:

(A) Standard amount of square footage per child is sixty (60) square feet. This may encompass educational and ancillary space;

(B) Standard amount of square footage per itinerant FTE position is one hundred twenty (120) square feet;

(C) Standard amount of square footage per administrative staff is one hundred twenty (120) square feet;

(D) Eligible pupils—

1. For Early Childhood Special Education (ECSE) programs—the number of students with disabilities who are educated at the leased facility and have instructional services in their Individualized Education Program (IEP) plus the number of non-disabled integrated peers who are educated at the leased facility. The number shall be determined based on the pupil enrollment on April 30 in the year for which facility lease payment is requested;

2. For the Missouri Preschool Program (MPP)—the number of slots approved by the department in the grant award for the program; and

3. For Elementary and Secondary Education Act (ESEA) preschools—the number of slots determined by the district and approved within the budget application for children who are educationally disadvantaged and are three (3), four (4), or five (5) years of age;

(E) Cost per square foot by county—

1. The highest rate per square foot for the county where the facility is located as computed based on the state lease facility space information per county obtained from the Office of Administration (OA) and posted on the department website annually; or

2. If there is no rate for an individual county, the lowest rate from the contiguous counties is used in the formula;

(F) Itinerant positions are instructional, diagnostic, and related services staff that travel from one (1) building/facility to a separate building/facility in order to provide instructional and related services as set forth in an IEP, or who provide services to eligible pupils outside the ECSE classroom, and are identified in the approved ECSE Final Expenditure Report (FER);

(G) Administrative positions are director and coordinator staff that are identified in the approved ECSE FER; and

(H) FTE is the number of total hours worked divided by the maximum number of compensable hours in a full-time schedule as defined by law.

(5) The formula will be used for facility lease costs incurred starting July 1, 2016. However, for leases that were fully signed and in effect on March 2, 2015, the formula will be used for facility lease costs incurred starting July 1, 2019 or the date the lease expires, whichever comes first.

(7) Early Childhood Special Education multi-district cooperative programs can request a waiver of the use of the formula from the department if the cooperative can validate that using a facility that exceeds the formula amount reduces the total cost of the cooperative Early Childhood Special Education Program for that year.

(8) Requests for payment shall be submitted to the department's finance section handling the costs for the specific early learning program in accordance with the deadlines for that program.

(9) Districts can have multiple early learning programs in the same building but the facility lease costs must be prorated among the programs based on a method approved by the department.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program**

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.424, 198.427, 198.431, 198.433, 198.436, and 208.159, RSMo 2000, sections 208.153 and 208.201, RSMo Supp. 2013, section 198.421, RSMo Supp. 2014, and section 198.439, RSMo Supp. 2015, the division amends a rule as follows:

**13 CSR 70-10.110 Nursing Facility Reimbursement Allowance
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 3, 2015 (40 MoReg 951-955). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2014, the division amends a rule as follows:

**13 CSR 70-15.010 Inpatient Hospital Services Reimbursement
Plan; Outpatient Hospital Services Reimbursement Methodology
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 3, 2015 (40 MoReg 956-957). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division received no comments on the proposed amendment.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.201 and 208.453, RSMo Supp. 2014, and section 208.455, RSMo 2000, the division amends a rule as follows:

**13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 3, 2015 (40 MoReg 958-963). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division received no comments on the proposed amendment.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 100—Insurer Conduct
Chapter 9—Filing Requirements**

ORDER OF RULEMAKING

By the authority vested in the director of the Missouri Department of Insurance, Financial Institutions and Professional Registration under sections 354.120, 354.723, 375.013, 376.675, 376.1025, 376.1095, 379.351, and 380.561, RSMo 2000, and sections 354.085, 354.485, 374.045, 374.056, 376.405, 376.777, 376.1399, 381.042, and 383.035, RSMo Supp. 2013, the director adopts a rule as follows:

20 CSR 100-9.100 Requirements for the Filing of Papers, Documents, or Reports with the Insurance Market Regulation Division **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 17, 2015 (40 MoReg 1032–1035). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed rule was held September 18, 2015 and the public comment period ended on September 18, 2015. At the public hearing, two (2) comments were made in support of the proposed rule and one (1) informational comment was made regarding the proposed rule. The department received two (2) written comments to the rule.

COMMENT #1: Grady Martin, Director of the Administration Division in the Department of Insurance, Financial Institutions and Professional Registration, spoke at the public hearing in support of the proposed rule and commented that utilizing electronic funds transfer for document filings will minimize the potential for billing errors and reduce labor necessary to receive payments.

RESPONSE: No changes have been made to the rule as a result of this comment.

COMMENT #2: Angela Nelson, Director of the Insurance Market Regulation Division in the Department of Insurance, Financial Institutions and Professional Registration, spoke at the public hearing in support of the proposed rule and commented that this rule formally adopts the System for Electronic Rate and Form Filing (SERFF), which will provide the following benefits: efficiency of the filing review process, expedited communications with companies during the review process, and improved accuracy of the filing reviews. Each of these benefits ultimately leads to improvement in the industry's speed to market for its products. The proposed rule also provides clarity as to timing regarding when products are submitted or resubmitted if revisions are necessary.

RESPONSE: No changes have been made to the rule as a result of this comment.

COMMENT #3: Carla Townsend, representing the National Council on Compensation Insurance (NCCI), both submitted written comment and testimonial comment at the hearing. Ms. Townsend questioned how this rule would affect the accessibility of nonpublic documents by the public and "the definition of reports that are 'legally required' as many reports are requested by the [department] but out-

side of the special request would not otherwise be submitted."

RESPONSE: This rule does not affect the confidentiality of documents nor does it alter the status of such. Further, Ms. Townsend's concern regarding the applicability of the definition of reports when such are requested by the department does not appear to be founded as such would not fall within the scope of this rule. As such, no changes have been made to the rule as a result of this comment.

COMMENT #4: Peter Quirk, representing the Insurance Services Office, Inc. (ISO) submitted a written comment questioning whether or not 20 CSR 100-9.100(3)(D), which addresses the replacement of one document for another within a filing, when read in conjunction with the definitions of "Document," "Filing Submission," and "Supersede" would cause confusion and require multiple, separate filings.

RESPONSE: The purpose behind 20 CSR 100-9.100(3)(D) and the concept of superseding documents is to marry together statutory language that was written at a time when filings were physically received and individually stamped and the advent of electronic filing, where documents within filings can be exchanged instantaneously and continuously. Rather than requiring a company to create a new filing each time a document is revised or only permitting one (1) document per individual filing, 20 CSR 100-9.100(3)(D) makes clear that companies can replace individual documents within a submitted filing without making an entirely new filing. But, each individual document must comply with all filing requirements except the filing fee (i.e., a document that was resubmitted under the wrong filing tab or incorrectly coded would not be processed as filed until the correction was made). Further, 20 CSR 100-9.100(3)(D) also clarifies that the statutory time to review the new document begins when the original document is superseded and a new document is submitted. This again reflects the electronic nature of filing reviews and allows the division and insurers the time necessary to work towards compliant filing submissions. As such, no changes have been made to the rule as a result of this comment.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation
Chapter 6—Surplus Lines**

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Insurance, Financial Institutions and Professional Registration under section 374.045, RSMo Supp. 2013, and section 384.018, RSMo Supp. 2014, the director adopts a rule as follows:

20 CSR 200-6.700 Procedures for Forming and Operating a Missouri Domestic Surplus Lines Insurer **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 17, 2015 (40 MoReg 1036–1037). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed rule was held September 18, 2015, and the public comment period ended September 18, 2015. At the public hearing, one (1) comment was made in support of the proposed rule.

COMMENT #1: John Rehagen, with the Division of Insurance Company Regulation in the Department of Insurance, Financial

Institutions and Professional Registration, spoke at the public hearing in support of the proposed rule with no suggested changes.

RESPONSE: No changes have been made to the rule as a result of this comment.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 400—Life, Annuities and Health
Chapter 11—Navigators**

ORDER OF RULEMAKING

By the authority vested in the director of the Missouri Department of Insurance, Financial Institutions and Professional Registration under sections 374.045, 376.2006, and 376.2014, RSMo Supp. 2013, the director adopts a rule as follows:

**20 CSR 400-11.140 Renewal Applications and Fees—Individual
Navigators and Entity Navigators is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 17, 2015 (40 MoReg 1037-1044). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed rule was held September 18, 2015 and the public comment period ended on September 18, 2015. At the public hearing, the department's Administration Division director explained the proposed rule. The department received two (2) comments on the rule.

COMMENT #1: Matt Barton, on behalf of the Missouri Association of Insurance Agents, commented that while his organization is supportive of the provisions of the proposed rule, the organization would like to see a maximum amount of time during which the department would accept a late renewal incorporated into the rule, similar to provisions in statute related to insurance producers.

RESPONSE: The Missouri Department of Insurance, Financial Institutions and Professional Registration appreciates the comment from the Missouri Association of Insurance Agents. The insurance producer statute referenced by Mr. Barton includes an explicit limit on the length of time that a license can be renewed. The navigator licensing statutes do not specify such a limitation. No changes have been made to the rule as a result of this comment.

COMMENT #2: Matt Barton, on behalf of the Missouri Association of Insurance Agents, also commented that the time period to which the late fee applies (i.e., per month) should be specified or somehow clarified.

RESPONSE: The department appreciates Mr. Barton's comment. The late fee requirement is self-explanatory. No changes have been made to the rule as a result of this comment.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Schedule of Compensation as Required by Section 105.005, RSMo

<u>Office</u>	<u>RSMo Citation</u>	<u>Statutory Salary FY 2015</u>	<u>Statutory Salary FY 2016</u>
<u>Elected Officials</u>			
Governor	26.010	\$133,821	\$133,821
Lt. Governor	26.010	86,484	86,484
Attorney General	27.010	116,437	116,437
Secretary of State	28.010	107,746	107,746
State Treasurer	30.010	107,746	107,746
State Auditor	29.010	107,746	107,746
<u>General Assembly</u>			
Senator	21.140	35,915	35,915
Representative	21.140	35,915	35,915
Speaker of House	21.140	38,415	38,415
President Pro Tem of Senate	21.140	38,415	38,415
Speaker Pro Tem of the House	21.140	37,415	37,415
Majority Floor Leader of House	21.140	37,415	37,415
Majority Floor Leader of Senate	21.140	37,415	37,415
Minority Floor Leader of House	21.140	37,415	37,415
Minority Floor Leader of Senate	21.140	37,415	37,415
<u>State Tax Commissioners</u>	138.230	106,620 **	106,620
<u>Administrative Hearing Commissioners</u>	621.015	103,960 **	103,960
<u>Labor and Industrial Relations</u>			
<u>Commissioners</u>	286.005	106,626 **	106,626
<u>Division of Workers' Compensation</u>			
Chief Legal Counsel *	287.615	95,486	110,046
Administrative Law Judge *	287.615	105,172	121,553
Administrative Law Judge in Charge *	287.615	110,172	126,553
Director, Division of Workers' Compensation*	287.615	112,172	128,553
<u>Public Service Commissioners</u>	386.150	106,625 **	106,625

	<u>RSMo Citation</u>	<u>Executive Level FY 2015</u>	<u>Executive Level FY 2016</u>
<u>Statutory Department Directors</u>	105.950		
Administration, Agriculture, Corrections, Economic Development, Labor and Industrial Relations, Natural Resources, Public Safety, Revenue, and Social Services		I	I
<u>Probation and Parole</u>	217.665		
Chairman		III	III
Board Members		IV	IV

* Division of Workers' Compensation salaries are tied to those of Associate Circuit Judges, subject to appropriation; the Fiscal Year 2015 budget does not include funding to match judicial salary levels.

** The 2015 salaries include a one-percent salary adjustment effective January 1, 2015.

Schedule of Compensation as Required by Section 476.405, RSMo

	<u>RSMo Citation</u>	<u>Highest Salary FY 2015</u>	<u>Highest Salary FY 2016</u>
<u>Supreme Court</u>			
Chief Justice	477.130	\$176,295 **	\$178,089 ***
Judges	477.130	168,636 **	170,292 ***
<u>Court of Appeals</u>			
Judges	477.130	154,176 **	155,709 ***
<u>Circuit Court</u>			
Circuit Court Judges	478.013	145,343 **	146,803 ***
Associate Circuit Judges	478.018	133,716 **	135,059 ***
<u>Juvenile Officers</u>	211.381		
Juvenile Officer		47,624 **	48,100
Chief Deputy Juvenile Officer		41,468 **	41,883
Deputy Juvenile Officer Class I		37,004 **	37,374
Deputy Juvenile Officer Class 2		33,740 **	34,077
Deputy Juvenile Officer Class 3		30,812 **	31,120
<u>Court Reporters</u>	485.060	56,612 **	57,178
<u>Probate Commissioner *</u>	478.266	127,020	145,343
	& 478.267		
Deputy Probate Commissioner *	478.266	116,858	133,716
<u>Family Court Commissioner *</u>	211.023	116,858	133,716
	& 487.020		
<u>Circuit Clerk</u>			
1st Class Counties	483.083	69,740 **	70,437
St. Louis City	483.083	112,453 **	113,578
Jackson, Jasper & Cape Girardeau	483.083	73,913 **	74,652
2nd & 4th Class Counties	483.083	62,900 **	63,529
3rd Class Counties	483.083	55,088 **	55,639
Marion-Hannibal & Palmyra	483.083	61,928 **	62,547
Randolph	483.083	60,164 **	60,766

* Salaries are tied to those of Circuit and Associate Circuit Judges, subject to appropriation; the Fiscal Year 2015 and Fiscal Year 2016 appropriations do not include funding to match judicial salary levels.

** The 2015 salaries include a one-percent salary adjustment effective January 1, 2015.

*** The Fiscal Year 2016 budget does not include the one-percent salary adjustment for these positions; the Judiciary implemented the increase through existing appropriations.

**Missouri Executive Pay Plan
Fiscal Year 2016**

Executive Level	Minimum	Maximum
I	\$86,484	\$125,724
II	\$79,296	\$115,068
III	\$72,768	\$105,408
IV	\$68,160	\$96,504
V	\$55,416	\$77,556

**Title 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and
Transportation Commission
Chapter 25—Motor Carrier Operations**

IN ADDITION

**7 CSR 10-25.010 Skill Performance Evaluation Certificates for
Commercial Drivers**

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce because of impaired vision or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below, on or before, January 4, 2016.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:

- *Email:* Pamela.lueckenotto@modot.mo.gov
- *Mail:* PO Box 270, Jefferson City, MO 65102
- *Hand Delivery:* 830 MoDOT Drive, Jefferson City, MO 65102
- *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

**COMMENTS RECEIVED
BECOME MoDOT PUBLIC RECORD**

- By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
- *Docket:* For access to the department's file, to read background documents or comments received, 830 MoDOT Drive, Jefferson City, MO 65102, between 7:30 a.m. and 4:00 p.m., CT, Monday through Friday, except state holidays.

FOR FURTHER INFORMATION CONTACT: Pam Lueckenotto, Motor Carrier Investigations Specialist, 636-288-6082, MoDOT Motor Carrier Services Division, PO Box 270, Jefferson City, MO 65102. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation

If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background

The individuals listed in this notice have recently filed applications

requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, RSMo, MoDOT may issue an SPE Certificate, for not more than a two- (2-) year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing an SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application #125

Renewal Applicant's Name & Age: Robert J. Ogle, 56

Relevant Physical Condition: Vision impaired.

Mr. Ogle had melanoma in his right eye and has monocular vision. His best uncorrected visual acuity in his left eye is 20/30 Snellen. Mr. Ogle has had this visual impairment since October 1997.

Relevant Driving Experience: Mr. Ogle has approximately seventeen (17) years of commercial motor vehicle experience. Mr. Ogle currently has a Class A license. In addition, he has experience driving personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in September 2015, a board-certified optometrist certified his condition would not adversely affect his ability to operate a commercial motor vehicle safely.

Traffic Accidents and Violations: Mr. Ogle has had no tickets or accidents on record for the previous three (3) years.

Request for Comments

The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: October 28, 2015

Scott Marion, Motor Carrier Services Director, Missouri Department of Transportation.

**Title 19—DEPARTMENT OF HEALTH AND
SENIOR SERVICES
Division 60—Missouri Health Facilities Review
Committee
Chapter 50—Certificate of Need Program**

**NOTIFICATION OF REVIEW:
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for December 22, 2015. These applications are available

for public inspection at the address shown below:

Date Filed

Project Number: Project Name
City (County)
Cost, Description

11/4/15

#5254 NT: Monroe Manor
Paris, MO (Monroe County)
\$1,567,880, Renovate and Modernize 119-bed SNF

11/9/15

#5265 NT: Columbia Healthcare Center
Columbia, MO (Boone County)
\$11,180,000, Replace 97-bed SNF

11/10/15

#5198 HT: St. Mary's Medical Center
Blue Springs, MO (Jackson County)
\$3,394,233, Replace Linear Accelerator

#5266 HT: Lester E. Cox Medical Center
Springfield, MO (Greene County)
\$2,280,989, Replace Interventional Radiology Angiography Unit

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 10, 2015. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102

For additional information contact
Alicia Wieberg, (573) 751-6403.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 2030—Missouri Board for Architects,
Professional Engineers, Professional Land Surveyors,
and Professional Landscape Architects**

NON-SUBSTANTIVE CHANGE REQUEST

The Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects requests that the secretary of state make a non-substantive change to the following division and subsequent chapters in accordance with the provisions of section 536.032, RSMo. Section 327.031, RSMo, was amended by SB 809 effective August 28, 2014. The division name was changed to add "Professional" before "Landscape Architects." The header should be changed to read, "Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects" for all chapters falling under Division 2030.

This change will appear in December 31, 2015 update to the *Code of State Regulations*.

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

**NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST
SCRIPT MASTERS, INC., d/b/a MEDICAP PHARMACY 108**

On October 28, 2015, Script Masters, Inc. filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective October 28, 2015. Said corporation requests that all persons and organizations who have claims against it present them immediately by letter to the corporation c/o Ronnie W. Hamra, 608 Salcedo Road, Sikeston, Missouri 63801. All claims must include the following information:

1. The name, address and telephone number of the claimant.
2. The amount of the claim.
3. The date on which the event on which the claim is based occurred.
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Script Master, Inc. will be barred unless the proceeding to enforce the claim is commenced within two (2) years after the publication date of the notices authorized by statute, whichever is published last.

**NOTICE OF CORPORATE DISSOLUTION
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
CORTNEY GENE, INC.**

On October 21, 2015, CORTNEY GENE, INC., a Missouri Corporation, filed its Articles of Dissolution with the Missouri Secretary of State.

Said corporation requests that all persons and organizations who have claims against it present them immediately by letter to: Lawrence E. Sidener, II, 1829 Borman Circle Drive, St. Louis, Missouri 63146.

Each claim must include: the name and address of the claimant; the amount claimed; the basis for the claim; the date(s) on which the event(s) on which the claim was based occurred; and whether the corporation has been previously notified of the claim, and, if so, when.

NOTICE: Because of the dissolution of CORTNEY GENE, INC., any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication date of the notices authorized by statute, whichever is published last.

CORTNEY GENE, INC.

By: Lawrence E. Sidener, II, Secretary
1841

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—39 (2014) and 40 (2015). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
OFFICE OF ADMINISTRATION					
1 CSR	Office of Administration				40 MoReg 851
1 CSR 10	State Officials' Salary Compensation Schedule				38 MoReg 2053 39 MoReg 2074 This Issue
1 CSR 10-15.010	Commissioner of Administration	40 MoReg 1345	40 MoReg 1346		
1 CSR 50-2.015	Missouri Ethics Commission		40 MoReg 1255		
1 CSR 50-2.020	Missouri Ethics Commission		40 MoReg 1256		
1 CSR 50-2.030	Missouri Ethics Commission		40 MoReg 1256		
1 CSR 50-2.040	Missouri Ethics Commission		40 MoReg 1256		
1 CSR 50-2.075	Missouri Ethics Commission		40 MoReg 1257		
1 CSR 50-2.100	Missouri Ethics Commission		40 MoReg 1257		
1 CSR 50-2.110	Missouri Ethics Commission		40 MoReg 1257		
1 CSR 50-2.120	Missouri Ethics Commission		40 MoReg 1258		
1 CSR 50-2.130	Missouri Ethics Commission		40 MoReg 1258		
1 CSR 50-2.140	Missouri Ethics Commission		40 MoReg 1259		
1 CSR 50-4.010	Missouri Ethics Commission		40 MoReg 1259		
DEPARTMENT OF AGRICULTURE					
2 CSR	Department of Agriculture				40 MoReg 851
2 CSR 30-10.010	Animal Health	40 MoReg 1623			
2 CSR 80-5.010	State Milk Board		40 MoReg 516	40 MoReg 1045	
2 CSR 80-6.041	State Milk Board		40 MoReg 518	40 MoReg 1045	
2 CSR 90-10	Weights and Measures				39 MoReg 1399 40 MoReg 1046
2 CSR 100-2.020	Missouri Agricultural and Small Business Development Authority		40 MoReg 1089	This Issue	
2 CSR 100-2.040	Missouri Agricultural and Small Business Development Authority		40 MoReg 1089	This Issue	
DEPARTMENT OF CONSERVATION					
3 CSR	Department of Conservation				40 MoReg 851
3 CSR 10-1.010	Conservation Commission		40 MoReg 1259		
3 CSR 10-5.205	Conservation Commission		40 MoReg 1261		
3 CSR 10-6.505	Conservation Commission		40 MoReg 1261		
3 CSR 10-7.410	Conservation Commission		40 MoReg 1262		
3 CSR 10-7.431	Conservation Commission		40 MoReg 1262		
3 CSR 10-7.434	Conservation Commission		40 MoReg 1263		
3 CSR 10-7.440	Conservation Commission		N.A. N.A.	40 MoReg 1045 40 MoReg 1317	
3 CSR 10-7.455	Conservation Commission		40 MoReg 1263		
3 CSR 10-10.722	Conservation Commission		40 MoReg 1264		
3 CSR 10-11.115	Conservation Commission		40 MoReg 1264		
3 CSR 10-11.130	Conservation Commission		40 MoReg 1265		
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3 CSR 10-12.140	Conservation Commission		40 MoReg 1274		
3 CSR 10-12.145	Conservation Commission		40 MoReg 1277		
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4 CSR 85-11.010	Division of Business and Community Services		40 MoReg 871	This Issue	
4 CSR 85-11.020	Division of Business and Community Services		40 MoReg 871	This Issue	
4 CSR 240-2.061	Public Service Commission		40 MoReg 520R	40 MoReg 1542R	
4 CSR 240-2.062	Public Service Commission		40 MoReg 520R	40 MoReg 1542R	
4 CSR 240-3.500	Public Service Commission		40 MoReg 520R	40 MoReg 1542R	
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4 CSR 240-3.513	Public Service Commission		40 MoReg 521R	40 MoReg 1543R	
4 CSR 240-3.515	Public Service Commission		40 MoReg 522R	40 MoReg 1543R	
4 CSR 240-3.520	Public Service Commission		40 MoReg 522R	40 MoReg 1544R	
4 CSR 240-3.525	Public Service Commission		40 MoReg 523R	40 MoReg 1544R	
4 CSR 240-3.530	Public Service Commission		40 MoReg 523R	40 MoReg 1544R	
4 CSR 240-3.535	Public Service Commission		40 MoReg 523R	40 MoReg 1544R	
4 CSR 240-3.540	Public Service Commission		40 MoReg 524R	40 MoReg 1545R	
4 CSR 240-3.545	Public Service Commission		40 MoReg 524R	40 MoReg 1545R	
4 CSR 240-3.550	Public Service Commission		40 MoReg 524R	40 MoReg 1545R	

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4 CSR 240-3.560	Public Service Commission		40 MoReg 525R	40 MoReg 1546R	
4 CSR 240-3.565	Public Service Commission		40 MoReg 526R	40 MoReg 1546R	
4 CSR 240-20.065	Public Service Commission		40 MoReg 526	40 MoReg 1486	
4 CSR 240-20.100	Public Service Commission		40 MoReg 538	40 MoReg 1499	
4 CSR 240-28.010	Public Service Commission		40 MoReg 555	40 MoReg 1546	
4 CSR 240-28.020	Public Service Commission		40 MoReg 555	40 MoReg 1547	
4 CSR 240-28.030	Public Service Commission		40 MoReg 556	40 MoReg 1548	
4 CSR 240-28.040	Public Service Commission		40 MoReg 558	40 MoReg 1548	
4 CSR 240-28.050	Public Service Commission		40 MoReg 559	40 MoReg 1549	
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4 CSR 240-28.070	Public Service Commission		40 MoReg 561	40 MoReg 1551	
4 CSR 240-28.080	Public Service Commission		40 MoReg 562	40 MoReg 1551	
4 CSR 240-28.090	Public Service Commission		40 MoReg 563	40 MoReg 1552	
4 CSR 240-30.020	Public Service Commission		40 MoReg 564R	40 MoReg 1553R	
4 CSR 240-30.040	Public Service Commission		40 MoReg 564R	40 MoReg 1553R	
4 CSR 240-32.010	Public Service Commission		40 MoReg 564R	40 MoReg 1553R	
4 CSR 240-32.020	Public Service Commission		40 MoReg 565R	40 MoReg 1553R	
4 CSR 240-32.040	Public Service Commission		40 MoReg 565R	40 MoReg 1554R	
4 CSR 240-32.050	Public Service Commission		40 MoReg 566R	40 MoReg 1554R	
4 CSR 240-32.060	Public Service Commission		40 MoReg 566R	40 MoReg 1554R	
4 CSR 240-32.070	Public Service Commission		40 MoReg 566R	40 MoReg 1554R	
4 CSR 240-32.080	Public Service Commission		40 MoReg 567R	40 MoReg 1555R	
4 CSR 240-32.090	Public Service Commission		40 MoReg 567R	40 MoReg 1555R	
4 CSR 240-32.100	Public Service Commission		40 MoReg 567R	40 MoReg 1555R	
4 CSR 240-32.120	Public Service Commission		40 MoReg 568R	40 MoReg 1555R	
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4 CSR 240-32.140	Public Service Commission		40 MoReg 569R	40 MoReg 1556R	
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4 CSR 240-32.170	Public Service Commission		40 MoReg 570R	40 MoReg 1557R	
4 CSR 240-32.180	Public Service Commission		40 MoReg 570R	40 MoReg 1557R	
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4 CSR 240-32.200	Public Service Commission		40 MoReg 571R	40 MoReg 1557R	
4 CSR 240-33.010	Public Service Commission		40 MoReg 571R	40 MoReg 1557R	
4 CSR 240-33.020	Public Service Commission		40 MoReg 572R	40 MoReg 1558R	
4 CSR 240-33.040	Public Service Commission		40 MoReg 572R	40 MoReg 1558R	
4 CSR 240-33.045	Public Service Commission		40 MoReg 572R	40 MoReg 1558R	
4 CSR 240-33.050	Public Service Commission		40 MoReg 573R	40 MoReg 1558R	
4 CSR 240-33.060	Public Service Commission		40 MoReg 573R	40 MoReg 1559R	
4 CSR 240-33.070	Public Service Commission		40 MoReg 574R	40 MoReg 1559R	
4 CSR 240-33.080	Public Service Commission		40 MoReg 574R	40 MoReg 1559R	
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4 CSR 240-33.140	Public Service Commission		40 MoReg 576R	40 MoReg 1561R	
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4 CSR 340-2	Division of Energy				40 MoReg 1046
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5 CSR	Department of Elementary and Secondary Education				40 MoReg 851
5 CSR 20-600.110	Division of Learning Services		40 MoReg 834	40 MoReg 1562	
5 CSR 30-4.030	Division of Financial and Administrative Services		40 MoReg 1277		
5 CSR 30-640.200	Division of Financial and Administrative Services		40 MoReg 834	This Issue	
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6 CSR	Department of Higher Education				40 MoReg 851
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7 CSR 10-25.030	Missouri Highways and Transportation Commission		40 MoReg 751	40 MoReg 1643	
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10 CSR 10-6.110	Air Conservation Commission		39 MoReg 1509	40 MoReg 138	
10 CSR 10-6.241	Air Conservation Commission		40 MoReg 1013		
10 CSR 10-6.250	Air Conservation Commission		40 MoReg 1023		
10 CSR 10-6.260	Air Conservation Commission		40 MoReg 621R	40 MoReg 1508R	
10 CSR 10-6.261	Air Conservation Commission		40 MoReg 621	40 MoReg 1508	
10 CSR 10-6.372	Air Conservation Commission		40 MoReg 753	40 MoReg 1562	
10 CSR 10-6.374	Air Conservation Commission		40 MoReg 765	40 MoReg 1565	
10 CSR 10-6.376	Air Conservation Commission		40 MoReg 777	40 MoReg 1572	
10 CSR 25-3.260	Hazardous Waste Management Commission		40 MoReg 626	40 MoReg 1575	
10 CSR 25-4.261	Hazardous Waste Management Commission		40 MoReg 629	40 MoReg 1576	
10 CSR 25-5.262	Hazardous Waste Management Commission		40 MoReg 631	40 MoReg 1577	
10 CSR 25-6.263	Hazardous Waste Management Commission		40 MoReg 639	40 MoReg 1587	
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10 CSR 25-12.010	Hazardous Waste Management Commission		40 MoReg 872		
10 CSR 25-13.010	Hazardous Waste Management Commission		40 MoReg 666	40 MoReg 1593	
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10 CSR 40-10.020	Land Reclamation Commission		40 MoReg 1173		
10 CSR 50-1.010	Oil and Gas Council		40 MoReg 1420		
10 CSR 50-1.020	Oil and Gas Council		40 MoReg 1420		
10 CSR 50-1.030	Oil and Gas Council		40 MoReg 1421		
10 CSR 50-1.040	Oil and Gas Council		40 MoReg 1424		
10 CSR 50-1.050	Oil and Gas Council		40 MoReg 1427		
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10 CSR 50-2.020	Oil and Gas Council		40 MoReg 1436		
10 CSR 50-2.030	Oil and Gas Council		40 MoReg 1442		
10 CSR 50-2.040	Oil and Gas Council		40 MoReg 1444		
10 CSR 50-2.050	Oil and Gas Council		40 MoReg 1450		
10 CSR 50-2.055	Oil and Gas Council		40 MoReg 1451		
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10 CSR 50-2.120	Oil and Gas Council		40 MoReg 1467		
10 CSR 50-3.010	Oil and Gas Council		40 MoReg 1467		
10 CSR 50-3.020	Oil and Gas Council		40 MoReg 1469		
10 CSR 50-4.010	Oil and Gas Council		40 MoReg 1472		
10 CSR 50-4.020	Oil and Gas Council		40 MoReg 1472		
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10 CSR 60-7.010	Safe Drinking Water Commission		40 MoReg 1201		
10 CSR 60-8.010	Safe Drinking Water Commission		40 MoReg 1202		
10 CSR 60-8.030	Safe Drinking Water Commission		40 MoReg 1204		
10 CSR 60-9.010	Safe Drinking Water Commission		40 MoReg 1216		

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11 CSR 45-4.030	Missouri Gaming Commission		40 MoReg 1280
11 CSR 45-9.030	Missouri Gaming Commission		40 MoReg 1281
11 CSR 45-9.050	Missouri Gaming Commission		40 MoReg 1283
11 CSR 45-9.060	Missouri Gaming Commission		40 MoReg 1283
11 CSR 45-9.101	Missouri Gaming Commission		40 MoReg 1283
11 CSR 45-9.103	Missouri Gaming Commission		40 MoReg 1284
11 CSR 45-13.051	Missouri Gaming Commission		40 MoReg 930
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11 CSR 45-30.025	Missouri Gaming Commission		40 MoReg 932
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11 CSR 45-30.070	Missouri Gaming Commission		40 MoReg 932
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11 CSR 45-30.145	Missouri Gaming Commission		40 MoReg 934R
11 CSR 45-30.150	Missouri Gaming Commission		40 MoReg 934
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11 CSR 45-30.180	Missouri Gaming Commission		40 MoReg 936
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11 CSR 45-30.235	Missouri Gaming Commission		40 MoReg 937
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11 CSR 45-30.280	Missouri Gaming Commission		40 MoReg 939R		
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11 CSR 45-30.340	Missouri Gaming Commission		40 MoReg 940		
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11 CSR 45-30.357	Missouri Gaming Commission		40 MoReg 941		
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11 CSR 75-18.010	Peace Officer Standards and Training Program		40 MoReg 232	40 MoReg 969	
11 CSR 75-18.020	Peace Officer Standards and Training Program		40 MoReg 233	40 MoReg 973	
11 CSR 75-18.030	Peace Officer Standards and Training Program		40 MoReg 234	40 MoReg 973	
11 CSR 75-18.040	Peace Officer Standards and Training Program		40 MoReg 234	40 MoReg 976	
11 CSR 75-18.050	Peace Officer Standards and Training Program		40 MoReg 235	40 MoReg 976	
11 CSR 75-18.060	Peace Officer Standards and Training Program		40 MoReg 235	40 MoReg 976	
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13 CSR 5-1.030	Office of the Director		40 MoReg 1090		
13 CSR 35-31.010	Children's Division		40 MoReg 838	40 MoReg 1511	
13 CSR 35-31.015	Children's Division (<i>Changed from 13 CSR 40-31.011</i>)		40 MoReg 1090		
13 CSR 35-60.010	Children's Division		40 MoReg 1476		
13 CSR 35-60.020	Children's Division		40 MoReg 1477		
13 CSR 35-60.030	Children's Division		40 MoReg 1478		
13 CSR 35-60.040	Children's Division		40 MoReg 1478		
13 CSR 35-60.050	Children's Division		40 MoReg 1479		
13 CSR 35-60.060	Children's Division		40 MoReg 1479		
13 CSR 35-60.080	Children's Division		40 MoReg 1479		
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13 CSR 35-60.110	Children's Division		40 MoReg 1482		
13 CSR 40-2.015	Family Support Division		40 MoReg 949	40 MoReg 1643	
13 CSR 40-2.300	Family Support Division	40 MoReg 1244	40 MoReg 1285		
13 CSR 40-2.310	Family Support Division	40 MoReg 1245	40 MoReg 1286		
13 CSR 40-2.315	Family Support Division	40 MoReg 1247	40 MoReg 1299		
13 CSR 40-31.011	Family Support Division (<i>Changed to 13 CSR 35-31.015</i>)		40 MoReg 1090		
13 CSR 40-31.012	Family Support Division		40 MoReg 1091R		
13 CSR 65-2.020	Missouri Medicaid Audit and Compliance		40 MoReg 838	40 MoReg 1511	
13 CSR 70-3.030	MO HealthNet Division		40 MoReg 1631		
13 CSR 70-10.015	MO HealthNet Division		40 MoReg 1633		
13 CSR 70-10.110	MO HealthNet Division	40 MoReg 923	40 MoReg 951	This Issue	
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13 CSR 70-15.110	MO HealthNet Division	40 MoReg 924	40 MoReg 958	This Issue	
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13 CSR 70-20.330	MO HealthNet Division		40 MoReg 1091		
13 CSR 70-20.340	MO HealthNet Division	40 MoReg 926	40 MoReg 964		
13 CSR 70-90.010	MO HealthNet Division		40 MoReg 719	40 MoReg 1318	
13 CSR 70-90.020	MO HealthNet Division		40 MoReg 720	40 MoReg 1318	
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20 CSR	Construction Claims Binding Arbitration Cap				39 MoReg 2149
20 CSR	Sovereign Immunity Limits				39 MoReg 2149
20 CSR	State Legal Expense Fund Cap				39 MoReg 2149
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20 CSR 400-11.140	Life, Annuities and Health	40 MoReg 1003	40 MoReg 1037	This Issue	
20 CSR 2030-1	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-1.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1534		
20 CSR 2030-2	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-2.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1534		
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1535		
20 CSR 2030-3	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-3.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1536		
20 CSR 2030-4	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-5	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-5.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1536		
20 CSR 2030-5.070	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1536		
20 CSR 2030-5.110	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1537		
20 CSR 2030-6	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-7	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-7.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1537		
20 CSR 2030-8	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-8.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1537		
20 CSR 2030-8.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1538		
20 CSR 2030-10	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-11	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-12	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-12.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		40 MoReg 1541		
20 CSR 2030-13	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-14	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-16	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue

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20 CSR 2030-19	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
20 CSR 2030-20	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects				This Issue
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11 CSR 30-12.020 Payments for Child Physical Abuse Forensic Examinations	This Issue	Nov. 12, 2015	May 9, 2016
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20 CSR 400-11.140 Renewal Applications and Fees—Individual Navigators and Entity Navigators40 MoReg 1003	July 25, 2015	Feb. 25, 2016

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20 CSR 2085-12.035 Requirements for Barber Schools	.40 MoReg 830	June 7, 2015	Feb. 25, 2016
20 CSR 2085-12.060 Requirements for Cosmetology Schools	.40 MoReg 831	June 7, 2015	Feb. 25, 2016
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20 CSR 2220-4.010 General Fees	.40 MoReg 1009	July 20, 2015	Dec. 1, 2015
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22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations	.40 MoReg 1251	Oct. 1, 2015	March 28, 2016
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22 CSR 10-3.160	Pharmacy Lock-In Program	This Issue	Jan. 1, 2015 June 28, 2016

Executive Orders

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2015			
15-08	Closes state offices Nov. 27, 2015.	Nov. 6, 2015	40 MoReg 1630
15-07	Dedicates and renames the state office building located at 8800 East 63rd Street in Raytown, Missouri, in honor of Joseph Patrick Teasdale, the 48th governor of the state of Missouri.	Oct. 28, 2015	40 MoReg 1628
15-06	Lays out policies and procedures to be adopted by the Executive Branch of state government in procuring goods and services to enhance economic health and prosperity of Minority and Women Business Enterprises. This order supercedes Executive Order 05-30.	Oct. 21, 2015	40 MoReg 1624
15-05	Extends Executive Order 15-03 until August 14, 2015.	July 14, 2015	40 MoReg 1012
15-04	Orders all departments, agencies, boards, and commissions to comply with the Obergefell decision and rescinds Executive Order 13-14.	July 7, 2015	40 MoReg 1010
15-03	Declares a state of emergency exist in the State of Missouri and directs that the Missouri State of Emergency Operations Plan be activated.	June 18, 2015	40 MoReg 928
15-02	Extends Executive Order 14-06 and orders that the Division of Energy deliver a state energy plan to the governor by October 15, 2015.	May 22, 2015	40 MoReg 833
15-01	Appoints Byron M. Watson to the Ferguson Commission to fill the vacancy created by the resignation of Bethany A. Johnson-Javois.	Jan. 2, 2015	40 MoReg 173
2014			
14-16	Extends Executive Order 14-07 and further orders that the Disparity Study Oversight Review Committee present its report to the governor and commissioner of administration by January 31, 2015.	Dec. 24, 2014	40 MoReg 129
14-15	Establishes the "Ferguson Commission" which shall study and recommend ways to make the St. Louis region a stronger, fairer place for everyone to live by studying the following subjects: 1) citizen-law enforcement interactions and relations; 2) racial and ethnic relations; 3) municipal government organization and the municipal court system; and 4) disparities in substantive areas.	Nov. 18, 2014	40 MoReg 5
14-14	Declares a state of emergency exists in the state of Missouri and directs the Missouri State Highway Patrol with the St. Louis County Police Department and the St. Louis Metropolitan Police Department to operate as a Unified command and ensure public safety in the City of Ferguson and the St. Louis Region and further orders the Adjutant General to call and order into service such portions of the organized militia as he deems necessary.	Nov. 17, 2014	39 MoReg 2116
14-13	Closes state offices Nov. 28, 2014.	Oct. 31, 2014	39 MoReg 1811
14-12	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Activation Plan be activated.	Oct. 22, 2014	39 MoReg 1809
14-11	Establishes the Office of Community Engagement.	Sept. 18, 2014	39 MoReg 1656
14-10	Terminates Executive Orders 14-08 and 14-09.	Sept. 3, 2014	39 MoReg 1613
14-09	Activates the state militia in response to civil unrest in the City of Ferguson and authorizes the superintendent of the Missouri State Highway Patrol to maintain peace and order.	Aug. 18, 2014	39 MoReg 1566
14-08	Declares a state of emergency exists in the state of Missouri and directs the Missouri State Highway Patrol to command all operations necessary in the city of Ferguson, further orders other law enforcement to assist the patrol when requested, and imposes a curfew.	Aug. 16, 2014	39 MoReg 1564
14-07	Establishes the Disparity Study Oversight Review Committee.	July 2, 2014	39 MoReg 1345
14-06	Orders that the Division of Energy develop a comprehensive State Energy Plan to chart a course toward a sustainable and prosperous energy future that will create jobs and improve Missourians' quality of life.	June 18, 2014	39 MoReg 1262
14-05	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	May 11, 2014	39 MoReg 1114
14-04	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	April 3, 2014	39 MoReg 1027
14-03	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	March 20, 2014	39 MoReg 958
14-02	Orders the Honor and Remember Flag be flown at the State Capitol each Armed Forces Day, held on the third Saturday of each May.	March 20, 2014	39 MoReg 956
14-01	Creates the Missouri Military Partnership to protect, retain, and enhance the Department of Defense activities in the state of Missouri.	Jan. 10, 2014	39 MoReg 491

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